DOCUMENT RESUME

ED 379 457 CE 068 270

TITLE	Skills for Health Care Assistants Vol. II. Supplemental Units for Health Care and Nurse Assistants Programs. Student Guide. Instructor Key. Revised.
INSTITUTION	Missouri Univ., Columbia. Instructional Materials Lab.
SPONS AGENCY	Missouri State Dept. of Elementary and Secondary Education, Jefferson City. Div. of Vocational and Adult Education.
PUB DATE	Aug 94
NOTE	323p.; For volume I, see ED 367 822.
AVAILABLE FROM	Instructional Materials Laboratory, University of Missouri-Columbia, 2316 Industrial Drive, Columbia, MO 65202 (order no. 90-5642-S, student guide; 90-5642-I, instructor key).
PUB TYPE	Guides - Classroom Use - Teaching Guides (For Teacher) (052) -- Guides - Classroom Use - Instructional Materials (For Learner) (051)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Evaluation Methods; High Schools; *Learning Activities; Learning Modules; *Medical Services; *Nurses Aides; *Nursing Homes; Personal Care Homes; Residential Care; State Curriculum Guides; Test Items; Units of Study
IDENTIFIERS	Missouri

ABSTRACT

This student guide for courses for health care assistants and nurse assistants contains 16 self-paced units with simplified line drawings, controlled text, vocabulary development, and mathematics practice exercises. Units consist of the following: objectives, introduction to the unit, content outline, steps of the procedure, skill sheets, written evaluations, practical exercises, and review exercises including matching, multiple-choice, and short answer items. An instructor key for the evaluation sections is provided. The units of study cover the following topics: (1) orientation to health services; (2) handwashing; (3) measuring intake and output; (4) assisting patients in using bedpans and urinals; (5) feeding patients; (6) bathing; (7) hair care; (8) mouth care; (9) shaving; (10) giving a backrub; (11) bedmaking; (12) body mechanics; (13) transferring; (14) temperature; (15) pulse and respiration; and (16) blood pressure. (KC)

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ED 379 457

Skills for Health Care Assistants Vol. II

Supplemental Units for Health Care and Nurse Assistants Programs

Student Guide

Instructor Key

Revised

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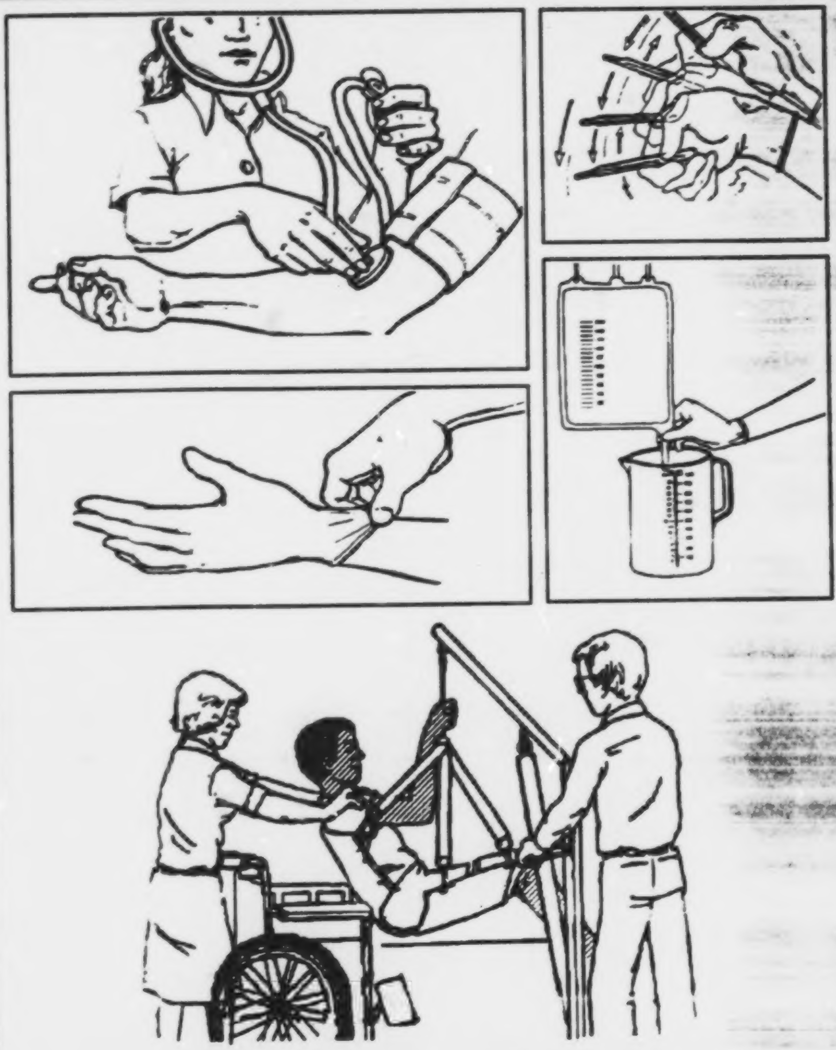
Supplemental Units for Health Care and Nurse Assistants Programs



Student Guide

Produced by the
Instructional Materials Laboratory
University of Missouri-Columbia
and the
Department of Elementary and Secondary Education
Jefferson City, Missouri

Available from:
Instructional Materials Laboratory
University of Missouri-Columbia
2316 Industrial Drive
Columbia, MO 65202
800-669-2465 or 314-882-2883

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SKILLS FOR
Health Care Assistants
Volume II

Supplemental Units for Health Care and Nurse Assistants Programs

Student Guide

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314-882-2883

July 1982
Revised August 1994

Catalog Number 90-5642-S

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Skills for Health Care Assistants

Preface

Skills for Health Care Assistants Volume II replaces the Health Services: Vocational Preparation Curriculum. The original manual was designed to provide supplementary materials for students enrolled in regular health services courses. The advisory committee for Volume I recommended that two curriculum guides, Supplementary Units for Nurse Assistant in a Long-Term Care Facility and Health Services: Vocational Preparation Curriculum be revised and combined under a new title, Skills for Health Care Assistants.Volume I was completed in 1993. Skills for Health Care Assistants curriculum was sponsored by the Missouri Department of Elementary and Secondary Education.

The units are self-paced and contain simplified line drawings, controlled text, vocabulary development, and math practice exercises. For ease of use, the color-coding has been changed to the following:

White:	Objectives, introduction to the unit, content outline, and steps of procedure are white pages.
Pink:	Skill sheets, written evaluations, and practical evaluations are pink pages. They are completed by the student and used by the instructor to evaluate student performance. Different forms of review, including matching, multiple-choice, and short answer exercises, are provided. Practical evaluations are included where appropriate. All pink sheets are to be returned to the instructor.

7

Orientation to Health Services

Unit Objective

After completing this unit, you should be able to determine rules of good patient care and staff relations, safety and fire prevention, and know what to record or report on a patient's chart using standard abbreviations.

Specific Objectives

After completing this unit, you should be able to:

A. Match key abbreviations to their correct definitions.

B. Identify rules of good patient care.

C. Identify rules of good staff relations.

D. Identify information reported or recorded on patient's chart.

E. Identify rules of safety.

F. Identify rules of fire prevention.

Introduction

Before you begin working with patients in a health care setting, you need to know some basic information about patient care and your responsibilities to the patient.

In this unit, you will learn about patient care, patient charting, staff relations, safety, and fire prevention. As you provide patient care, keep this information in mind so that you can work correctly and safely with your patients.

A. Key Abbreviations

a.m. - morning

p.m. - evening

q̄ - every

qd or q.d. - every day

bid or b.i.d. - twice daily

tid or t.i.d. - three times a day

qid - four times a day

stat, Stat or STAT - immediately

prn or PRN - whenever necessary

a.c. or ac - before meals

p.c. or pc - after meals

hs - at bedtime

NPO - nothing by mouth

c̄ - with

s̄ - without

ml - milliliter

cc - cubic centimeter

I & O - Intake and Output

BM - bowel movement

BP - blood pressure

TPR - temperature, pulse, and respirations

Wt or wt - weight

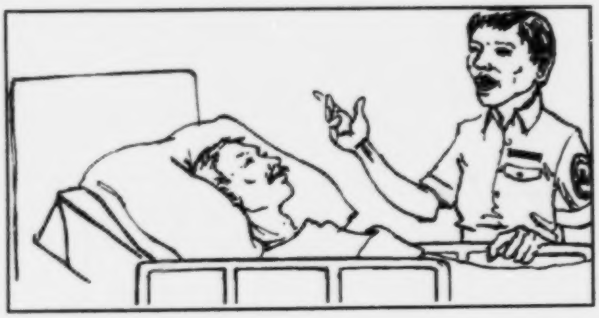
Pt or pt - patient

P.T. - physical therapy

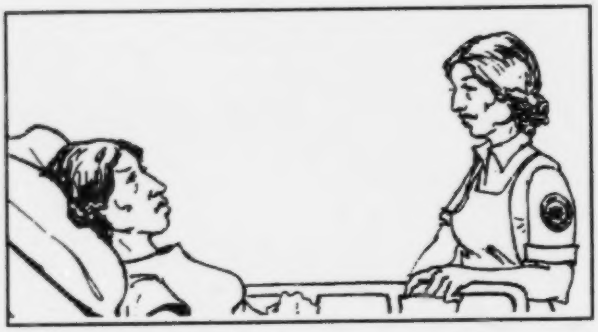
A.D.L. or ADL - activities of daily living

B. Rules of Good Patient Care

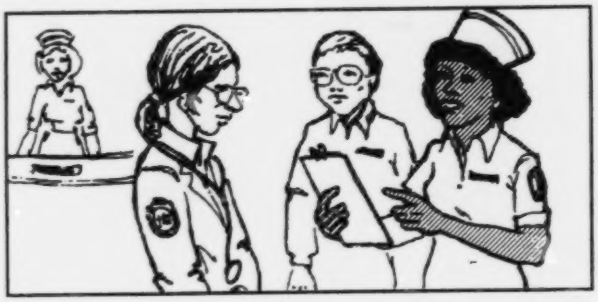
- See and treat each patient as a special person rather than as "just another patient."
- Always tell a patient what you are going to do before beginning any patient care. Example: "Hello, Mr. Doe, I'm __________ and I am going to help you with your bath this morning."



- Try to imagine yourself as the patient and understand how the patient might feel.
- Do not discuss a patient with anyone except health care personnel working with that patient. The term for this is confidentiality.



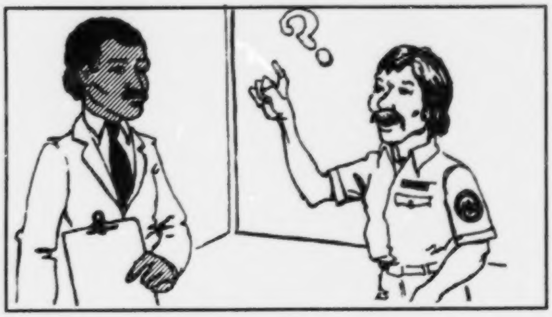
- If you make a mistake or forget to do something, report it to your supervisor.



- Give every patient the best care you are able to give.

C. Staff Relations

- Carefully follow instructions given by your supervisor. If you have a question, get it answered before starting to work.

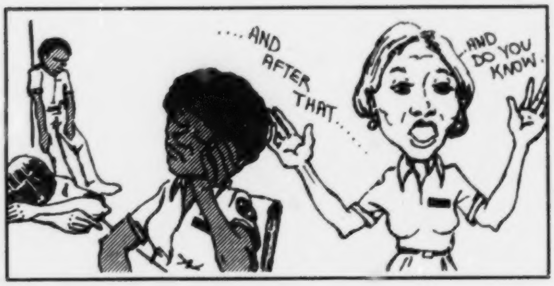


- Think of yourself as part of a team whose goal is to provide quality patient care. Cooperate with other members of the team.

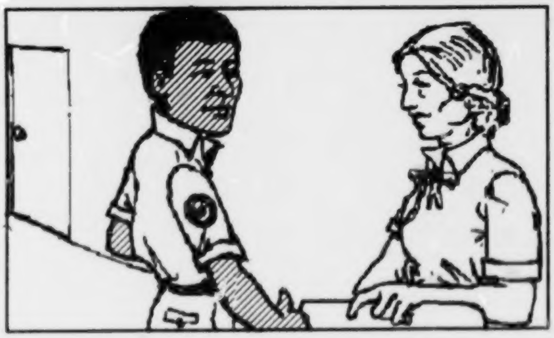
- If you have difficulty working with another staff member, discuss it with your supervisor.

NOTE: If the difficulty is with your immediate supervisor, discuss the problem with your supervisor's supervisor.

- Do not discuss personal problems with other staff members.

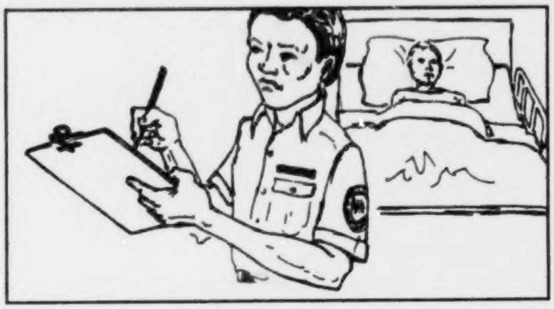

....AND AFTER THAT.....
..AND DO YOU KNOW..

- Report to your supervisor and get permission whenever you need to leave the floor or unit. For example at breaktime check with your supervisor before leaving the floor.



D. Charting

- Each patient has a chart with forms for recording temperature, pulse, respirations, blood pressure, intake and output, and other patient information.

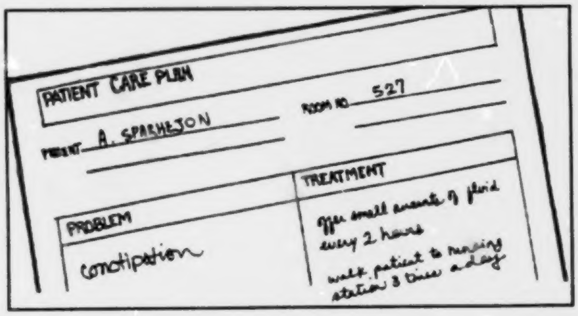


- Daily care routines (bathing, shaving, oral hygiene, etc.) are charted by the person completing the task. Usually a check chart is used.

  a. Check the appropriate square.
  b. Check the appropriate description of action.

- Often an Intake and Output form is kept at the bedside. Information on this form must be transferred to the main chart at the end of each shift. Usually this is charted by the charge nurse.

- Each patient should have a patient care plan. This describes the patient's problems and possible treatments.



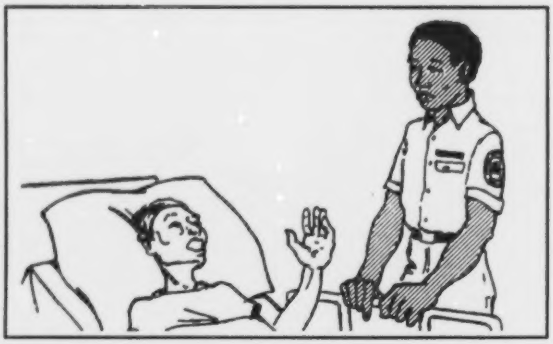
PATIENT CARE PLAN

PATIENT A. SPARHESON

ROOM NO. 527

PROBLEM	TREATMENT
constipation	offer small amounts of fluid every 2 hours walk patient to nursing station 3 times a day

- You probably will spend more time with the patient than your supervisor will, so it is important that you are aware of problems and report them immediately.



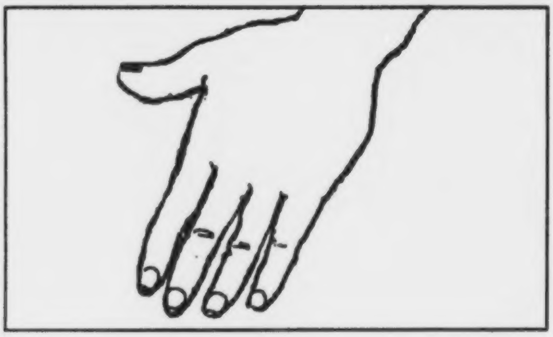
- Keys to Good Charting and Reporting

1. Describe what you see precisely and exactly. Example: Mrs. Cagney ate half of her lunch.

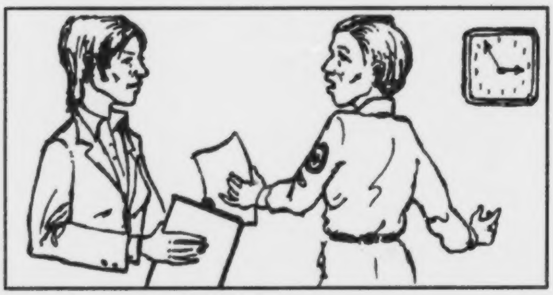
2. Describe what you hear: Use direct quotes when describing an emotional statement. Example: Mr. Jones stated, "I am so depressed today."

3. Describe what you smell. Example: The patient has a fruity odor to her breath.

4. Describe what you touch. Example: The patient's skin is cold and clammy.

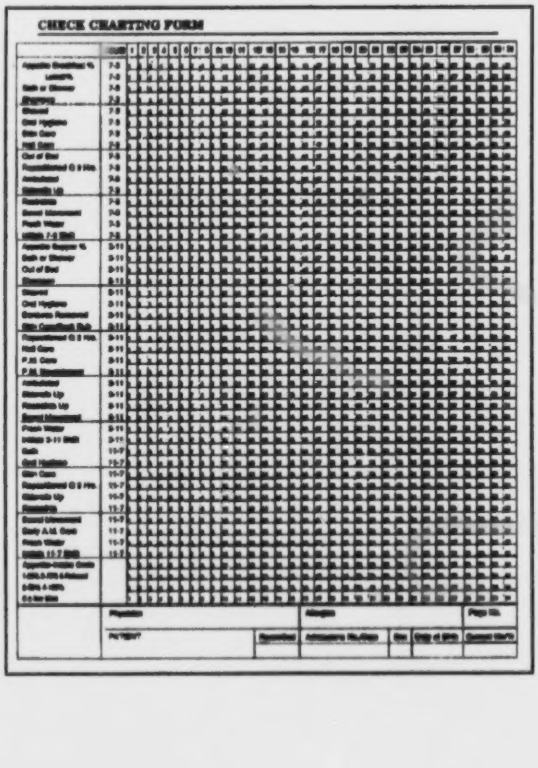


5. If you are not allowed to write on the patient's chart, give patient information in writing to your supervisor at the end of the shift. Remember, report specific problems immediately.



6. Information you want to report is:
   - How patient is feeling
   - Fluid intake and output
   - How the patient slept
   - Whether patient got out of bed
   - If you finished the patient's care
   - Any special problems

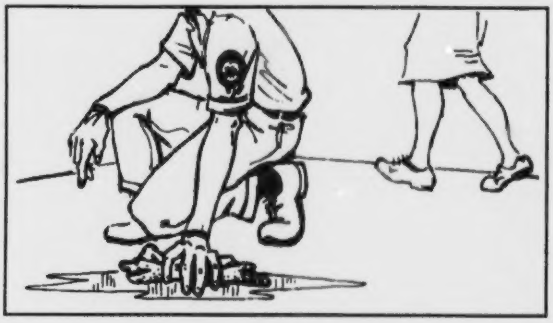
NOTE: Never chart a procedure before it is completed.



CHECK CHARTING FORM

E. Safety Rules

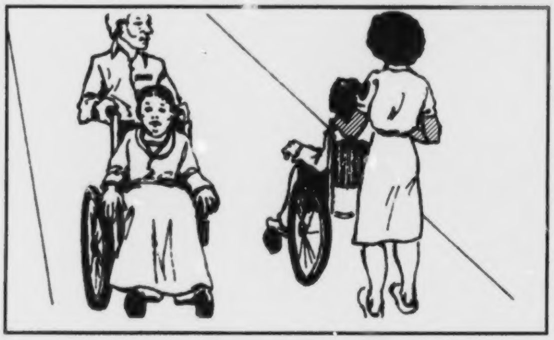
- Keep the floor clean and dry.



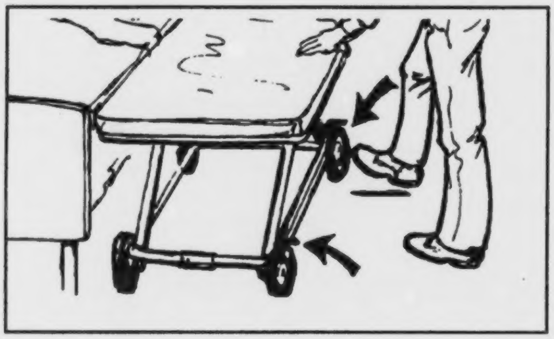
NOTE: See facility policy regarding spills such as blood.

- Walk! Never run in halls or on stairs.

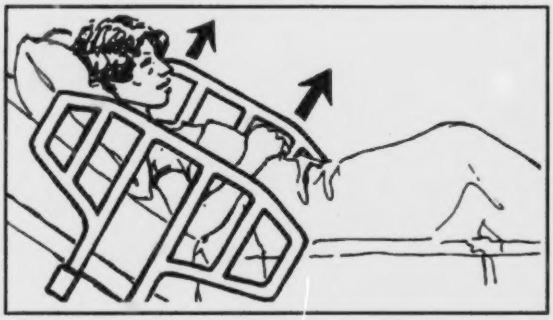
- Keep to the right when transporting patients in hallways.



- Be sure to lock the wheels of stretchers, beds, and wheelchairs when moving patients onto or off of such equipment.

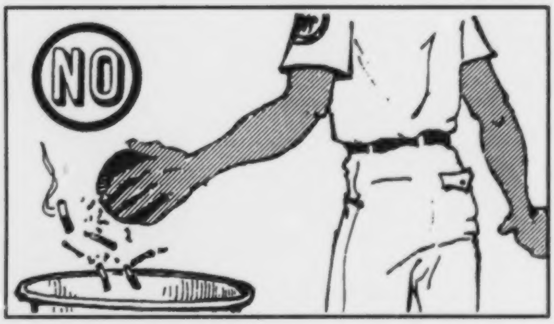


- After caring for a patient, pull up side rails if appropriate.



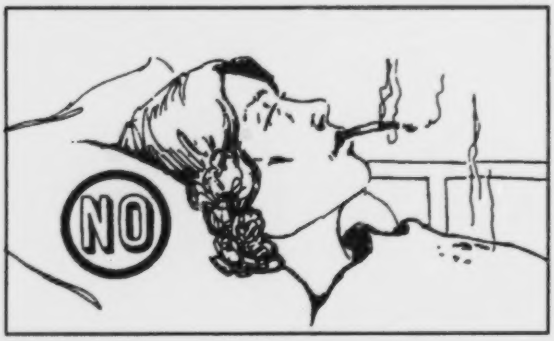
F. Fire Prevention

- Never empty ashtrays into wastebaskets.

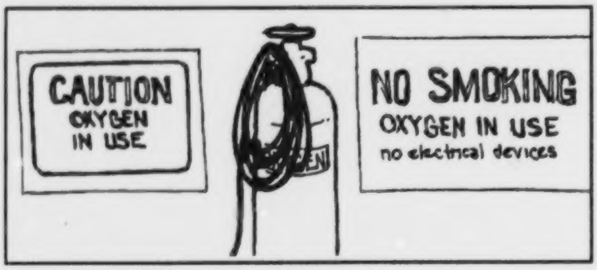


- Do not allow a patient who is drowsy or not fully alert to smoke.

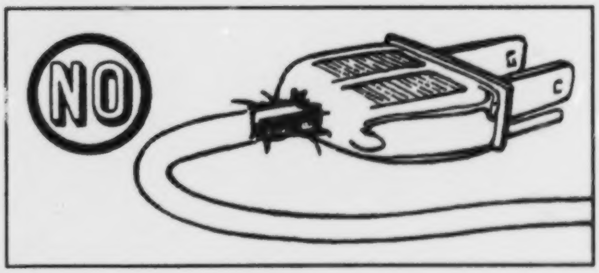
NOTE: Patient may not be allowed to smoke except in a designated area.



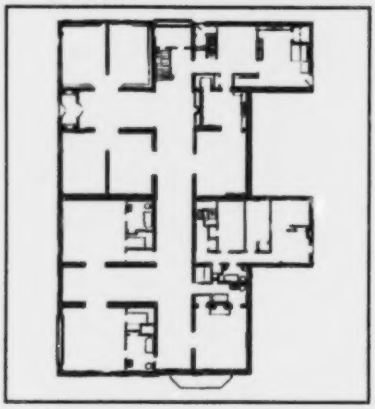
- Do not allow smoking where oxygen is being used.
- Do not use petroleum-based products (example: Vasoline® petroleum jelly) on patient who is receiving oxygen.
- Do not allow use of electrical razors in rooms where oxygen is being used.


CAUTION
OXYGEN
IN USE
NO SMOKING
OXYGEN IN USE
no electrical devices

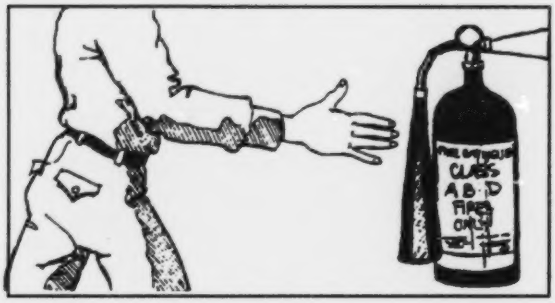
- Always report frayed wires or defective outlets.



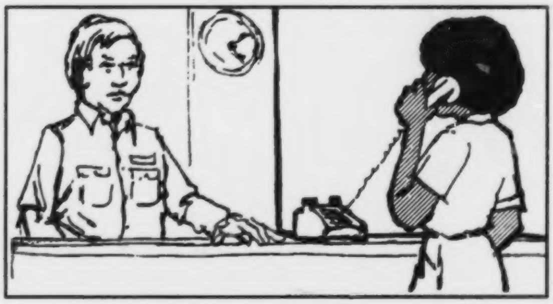
- Know the floor plan of your unit and where emergency exits are located.



- Know location of fire alarms and fire extinguishing devices.



- Know how to report a fire. Participate in fire drills.



- Become familiar with and discuss the emergency plan of your institution with your supervisor and staff members.

Orientation to Health Services
Written Evaluation

Match abbreviations in Column A to definitions in Column B.

Column A

______1. a.m.

______2. A.D.L.

______3. cc

______4. I & O

______5. prn

______6. TPR

______7. NPO

Column B

a. Whenever necessary
b. Cubic centimeter
c. Intake and Output
d. Morning
e. Activities of daily living
f. Nothing by mouth
g. Temperature, pulse and respirations

Identify rules of good patient care by writing "yes" beside each rule and "no" if it is not a good rule.

8. ______See and treat each patient as a special person rather than as "just another patient."

9. ______Give every patient the best care you are able to give.

10. ______Discuss a patient with your friend or neighbor.

Circle the letter that corresponds to the best answer.

11. To have good staff relations you should:

    a. Carefully follow instructions given by your supervisor.
    b. Not discuss your personal problems with other staff members.
    c. Report to your supervisor and get permission whenever you must leave your unit or floor.
    d. All of the above.

12. The following information is to be reported or charted on the patient's chart.

    a. How the patient is feeling.
    b. How the patient slept.
    c. Any complaints.
    d. All of the above.

13. Keep the floor clean and:

    a. Polished.
    b. Waxed.
    c. Dry.
    d. Sticky.

14. When should you pull up side rails after caring for a patient?

    a. Pull up side rails if appropriate.
    b. Pull up side rails as desired.
    c. Pull up side rails always.
    d. Pull up side rails only if patient asks you to.

15. You should empty ashtrays in wastebasket:

    a. Always.
    b. Sometimes.
    c. Never.
    d. When the charge nurse asks you to.

16. Know location of fire extinguishing devices and:

    a. Light switches.
    b. Fire alarms.
    c. Nurse's station.
    d. Closets.

Handwashing

Unit Objective

After completing this unit, you should be able to identify the most important times to wash your hands and to wash hands according to steps of procedure.

Specific Objectives

After completing this unit, you should be able to:

A. Identify when to wash your hands.

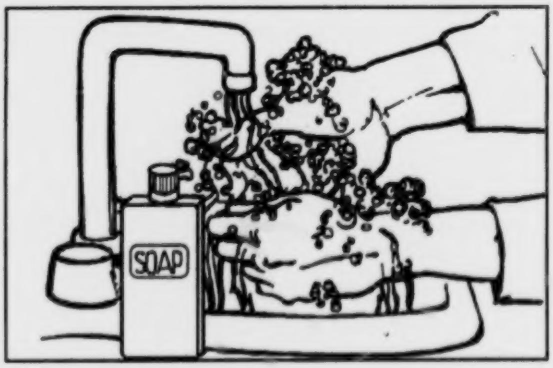
B. Wash hands according to steps of procedures.

Introduction

Handwashing is an important way to stop the spread of disease, both in patients and persons who care for patients. Every day we touch things that have disease-causing germs which can enter the body and expose us to a disease.

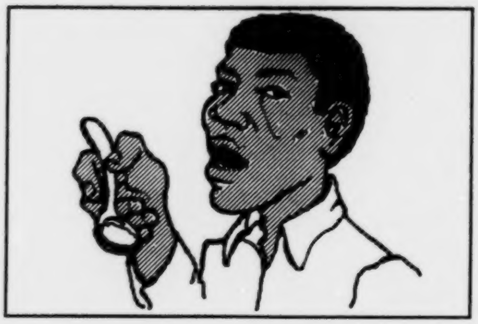
By washing hands regularly and correctly, you can stop the spread of disease-causing germs by destroying them before they have a chance to do harm.

In this unit, you will learn when and how to wash your hands.

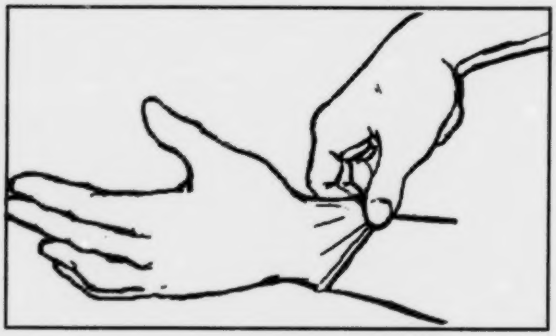


A. When to Wash Your Hands

- When you first come on duty and before going home.
- Before eating or having any contact with food.

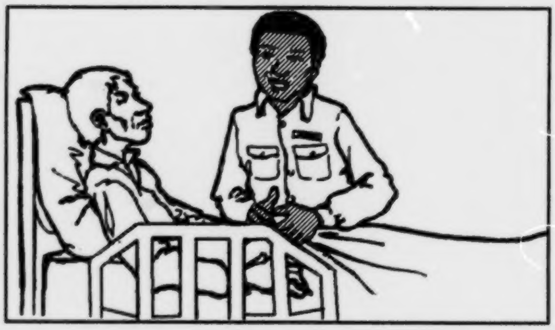


- Before and after using the bathroom or smoking.
- Before putting on and after removing gloves.

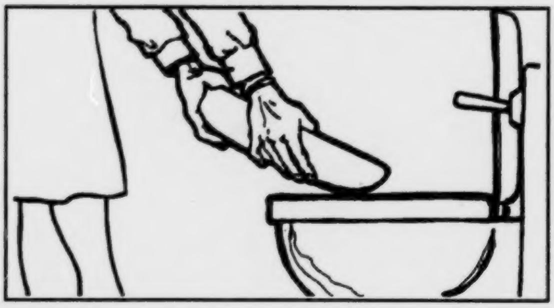


- Before and after caring for a patient.

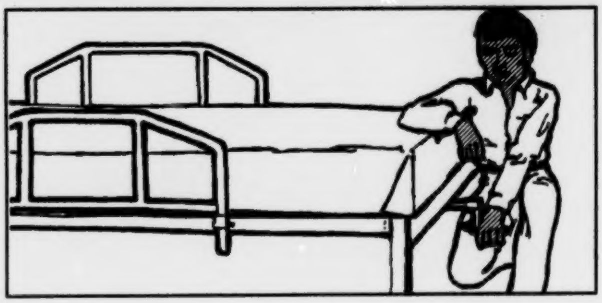
NOTE: Always wash hands before and after completing a procedure.



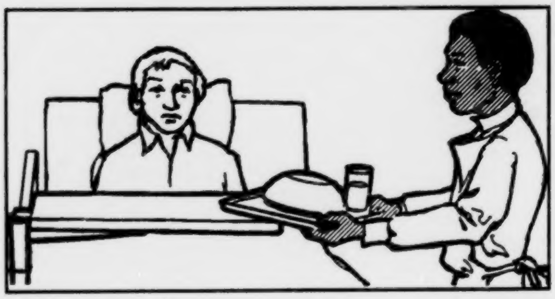
- After emptying a bedpan or having any contact with patient's waste or body fluids.



- After handling equipment used in patient care.



- Before and after handling patient's food tray.



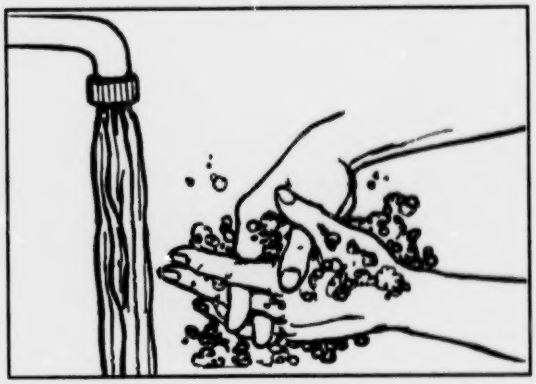
B. Steps of Procedure for Handwashing

1. Remove watch and/or rings, roll up sleeves. (Wash watch and rings if they have come into contact with contaminated materials.)

2. Turn on water with knee, foot, or hand controls. Adjust temperature so it is comfortable for you.

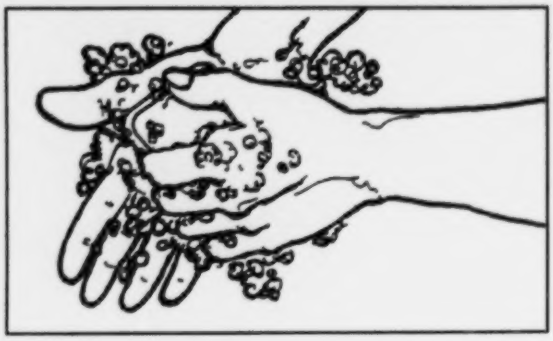
CAUTION: Do not turn controls during procedure.

3. Wet hands 2"-3" above wrists. Hold hands with wrists lower than elbows and fingertips pointed downward.

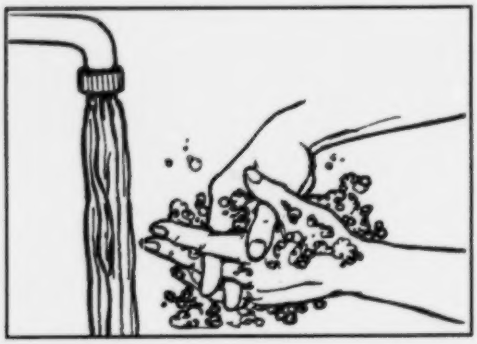


4. Apply a generous amount of soap to hands and on wrists and work up a lather. If bar soap is used, rinse it well before lathering and before returning it to the dish.

NOTE: Never use patient's bar soap.

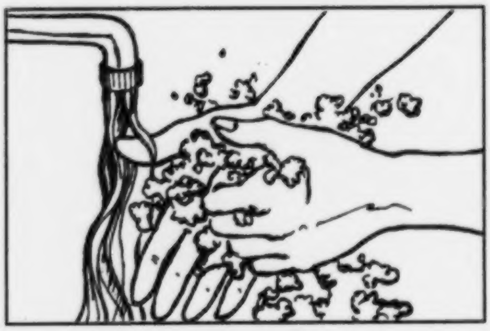


5. Scrub hands for at least 15 seconds.



6. Wash palms and back of hands with at least ten circular motions.

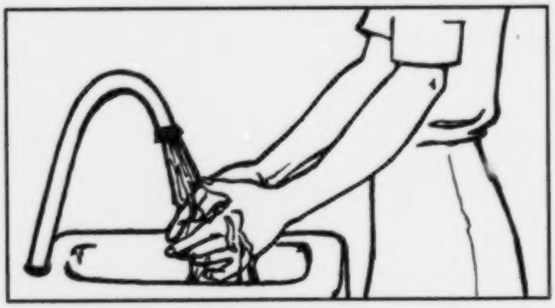
7. Wash fingers and between fingers with at least ten circular motions. Rub tips of fingers over palm of hand and push lather under fingernails.



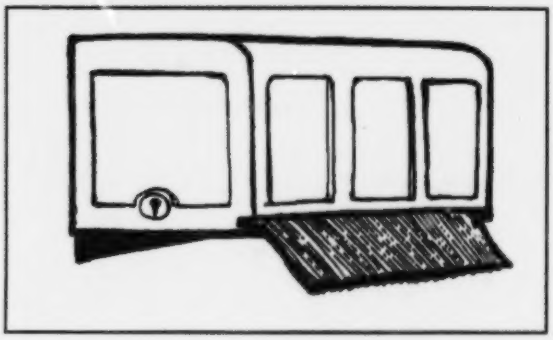
8. Wash wrists with at least ten circular motions.

9. Rinse wrists and hands well; keep wrists lower than elbows.

REMEMBER: Do not touch faucet controls.

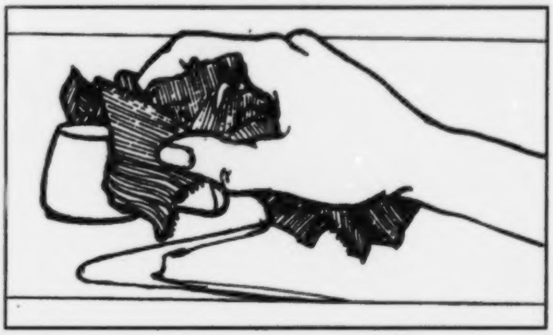


10. Dry hands with paper towels, using one for each hand.

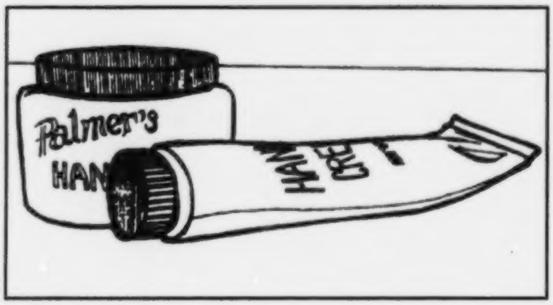


11. Turn off faucet controls with paper towel.

12. Throw paper towel in wastebasket without touching the part that touched the faucet.



13. Apply lotion to hands to avoid dry chapped skin. Dry, chapped skin is an easy target for germs.



Handwashing
Written Evaluation

Circle the letter that corresponds to the best answer.

1. Wash your hands:

   a. When coming on and leaving duty.
   b. When handling patient waste, such as when emptying a bedpan.
   c. Before and after giving patient care.
   d. All of the above.

2. You should always wash your hands:

   a. Before eating.
   b. After eating.
   c. While eating.
   d. After each bite.

Check examples of times to wash your hands.

_________ 3. Before and after using the bathroom

_________ 4. Before and after giving patient care

_________ 5. Before talking to patients

_________ 6. Before putting on and after removing gloves

_________ 7. Before reading the newspaper

Handwashing
Evaluation

_____________________ has successfully performed the following steps of procedure.
(Student)

Handwashing		Yes	No	Comments
1.	Remove watch and/or rings, roll up sleeves. (Wash watch and rings if they have come into contact with contaminated materials.)			
2.	Turn on water with knee, foot, or hand controls. Adjust temperature so it is comfortable for you. **CAUTION:** Do not turn controls during procedure.			
3.	Wet hands 2"-3" above wrists. Hold hands with wrists lower than elbows and fingertips pointed downward.			
4.	Apply a generous amount of soap to hands and on wrists and work up a lather. If bar soap is used, rinse it well before lathering and before returning it to the dish. **NOTE:** Never use patient's bar soap.			
5.	Scrub hands for at least 15 seconds.			
6.	Wash palms and back of hands with at least ten circular motions.			
7.	Wash fingers and between fingers with at least ten circular motions. Rub tips of fingers over palm of hand and push lather under fingernails.			
8.	Wash wrists with at least ten circular motions.			
9.	Rinse wrists and hands well; keep wrists lower than elbows. **REMEMBER:** Do not touch faucet controls.			
10.	Dry hands with paper towel, using one for each hand.			
11.	Turn off faucet controls with paper towel.			
12.	Throw paper towel in wastebasket without touching the part that touched the faucet.			
13.	Apply lotion to hands to avoid dry chapped skin. Dry, chapped skin is an easy target for germs.			

_____________________ _____________________

Student's Signature/Date

Instructor's Signature/Date

Measuring Intake and Output

Unit Objective

After completing this unit, you should be able to measure and record a patient's intake and output of fluids and distribute drinking water to patients.

Specific Objectives

After completing this unit, you should be able to:

A. Match terms in this unit with their correct definitions.

B. Identify three routes to administer fluids.

C. Identify guidelines in measuring and recording intake and output.

D. Identify fluids which must be measured/recorded for oral intake.

E. Convert liquid measurement in ounces to cubic centimeters (milliliters).

F. Identify fluids which must be measured/recorded for output.

G. Measure fluid intake according to steps of procedure.

H. Measure fluid output according to steps of procedure.

I. Measure urinary output from catheter according to steps of procedure.

J. Distribute drinking water according to steps of procedure.

Introduction

Fluid intake is the amount of fluid or liquid a patient takes in each day. Fluid output is the amount of fluid or liquid a patient loses each day. Most of this is in the form of urine. Normally, a person's fluid intake should be about the same as fluid output.

A doctor must know exactly how much fluid is taken in and lost or put out by certain patients. It is your responsibility to observe, measure, and record intake and output of fluids for your patients.

Water is an important part of a patient's fluid intake. Fresh water should be at the bedside of patients at all times, thus it is passed out at regular intervals during the day.

In this unit, you will learn how to measure intake and output, and distribute drinking water according to steps of procedure.

A. Terms

I & O - intake and ouput; intake is the amount of fluid or liquid a patient takes in each day; output is the amount of fluid or liquid a patient loses each day

I & O sheet - paper on which all fluid a patient takes in or puts out is recorded

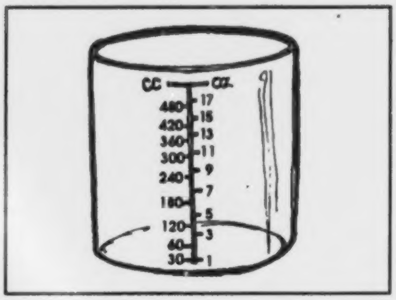
Diarrhea - frequent liquid bowel movement

Emesis - vomitus

Dehydration - a condition in which the body has less than the normal amount of fluid

Frequent fluids (F.F.) - extra fluids to be taken in by the patient according to the doctor's orders

Graduate - a measuring cup marked along its side to show various amounts so that the liquid placed in the cup can be measured accurately; the marks are called calibrations



Diaphoresis - excessive sweating

Edema - abnormal swelling of a part of the body caused by fluid collecting in that area; usually the swelling is in the ankles, legs, hands, or abdomen

B. Routes Used to Administer Fluids

- **Oral** - by mouth
- **Intravenous (IV)** - into the vein
- **Nasogastric (NG) tube** - tube through the nose and into the stomach
- **Gastrostomy tube** - tube placed directly into the stomach

C. Guidelines in Measuring and Recording Intake and Output

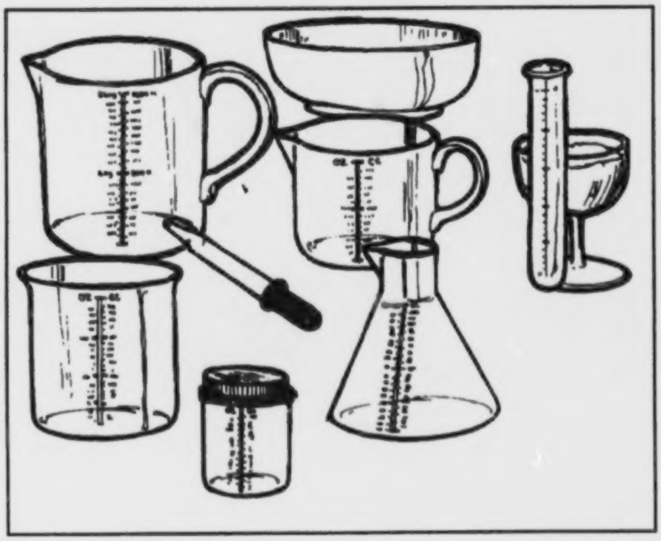
- Average oral intake for an adult is 2,000 to 3,000 cc of fluid per day, which is approximately the size of a 2-liter bottle of soda. Output should be about the same.

- A physician may restrict or encourage fluid intake. It is the charge nurse's responsibility to know which has been ordered and to pass this information on to the health care assistant.

- When intake and output (I&O) is ordered, accuracy is very important. Also, the patient and the patient's family should be informed of the procedure. All liquids the patient drinks between meals should be recorded.

- Paper and pencil are usually kept at the patient's bedside for each eight-hour shift to record intake and output.

- Checking and recording liquid intake at mealtime and between meals is a caregiver's responsibility.



- Intake and output are totaled and recorded at the end of each shift and at the end of the 24-hour period.

- At mealtime, check patient's tray before serving and after patient has eaten to determine intake of liquids. Remember, foods that turn liquid if allowed to stand at room temperature are also counted. Different containers hold different amounts. Practice measuring amounts in them.

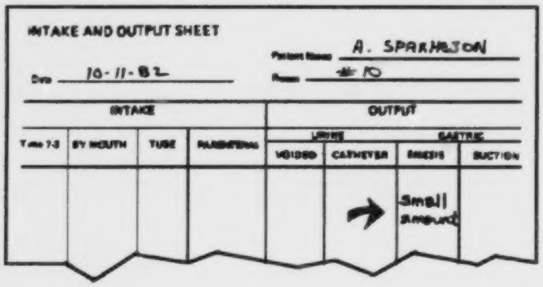
- Before emptying the water pitcher, measure water that is left to determine the amount consumed by the patient. Measure the amount the patient leaves and subtract that from the total amount the pitcher holds.

- Observe patient for signs of dehydration or edema. Symptoms include:

Dehydration	**Edema**
thirst	swelling
dryness of skin	shortness of breath
dryness of mucous membranes	weight increase
constipation	urine decrease
urine decrease	
fall in blood pressure	
rise in temperature	
loss of tissue elasticity	
dizziness	
mental confusion	

- Measure urinary output accurately each time bedpan, urinal, or bedside commode is emptied using a graduate.

- Measure and record any other body discharges such as vomitus, diarrhea, fluid in suction apparatus, and drainage on dressings. Record diaphoresis on input and output sheet if patient perspires profusely. If unable to measure accurately, estimate small, medium or large amount and record estimated amount on I&O sheet.



INTAKE AND OUTPUT SHEET

Date 10-11-82

Patient Name A. SPARKHEJON

Room #10

INTAKE				OUTPUT			
				URINE		GASTRIC	
Time 7-3	BY MOUTH	TUBE	PARENTERAL	VOIDED	CATHETER	EMESIS	SUCTION
						Small amount	

- Measure fluids in a rigid container. A catheter bag is not accurate so drain it into a graduate before observing and recording output.

- When looking at a graduate, read it at eye level. Place the graduate on a flat surface for accuracy in measurement.

- If the patient is incontinent, record the number of times on the I&O sheet.

D. Fluids Which Must be Measured for Oral Intake

- Water, coffee, tea, broth, ice chips, gelatin

- Juices, carbonated beverages (soda)

- Ice cream, milk shakes, sherbet, milk, cream

REMEMBER: Foods that turn liquid if allowed to stand at room temperature are considered liquid.

E. Convert from Household to Cubic Centimeters (cc), or Milliliters (ml)

1 cc = 1 ml

1 tsp = 5 cc (5 ml)

1 pt = 500 cc (500 ml)

1 qt = 1,000 cc (1,000 ml)

1 cup (8 oz) = 240 cc (240 ml)

1 oz = 30 cc (30 ml)

a. If 1 oz = 30 cc, then 8 oz would = 240 cc
8 oz X 30 cc/oz = 240 cc

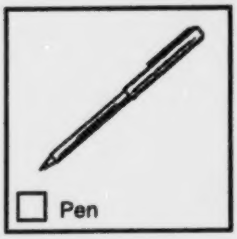
b. This formula can be applied to any amount, example: 6 oz = 180 cc
6 oz X 30 cc/oz = 180cc

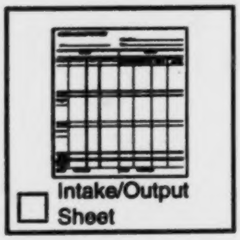
F. Fluids Which Must be Measured/Recorded for Output

- Urine
- Vomitus
- Diarrhea
- Drainage on dressings
- Perspiration

G. Steps of Procedure for Measuring and Recording Fluid Intake

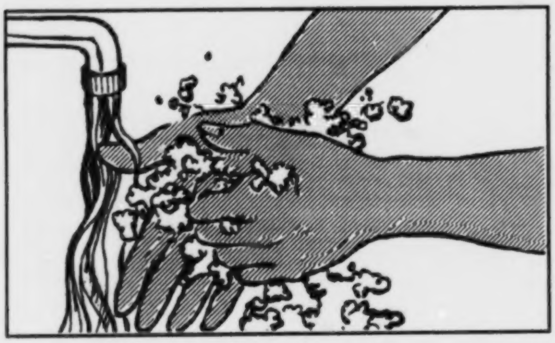
1. Assemble equipment.


☐ Pen


☐ Intake/Output Sheet

2. Wash hands.

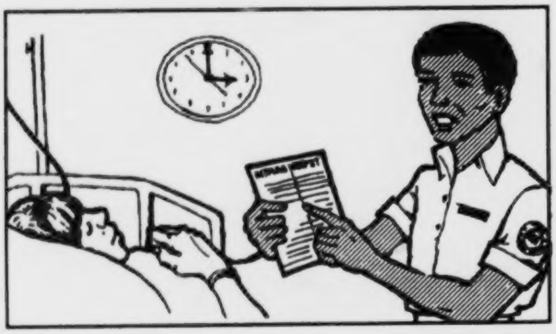
3. Identify and greet patient.



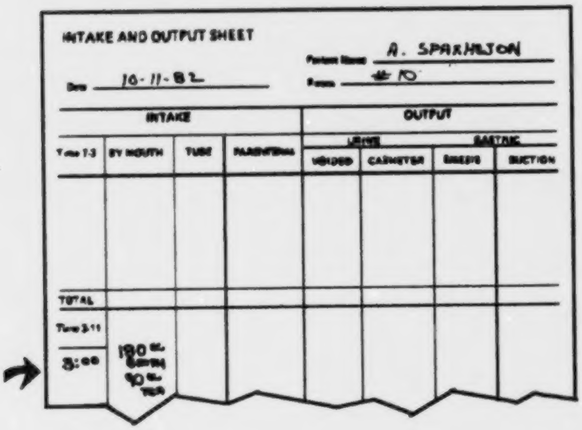
4. Identify yourself and tell patient what you plan to do.

NOTE: Tell patient he may help by recording fluid he takes by mouth.

5. Record intake on the Intake and Output sheet at the bedside. Intake includes the amount of liquid patient takes with meals and the amount of water and other liquids taken between meals.



6. Write down the time and record the amount of cc/ml.



INTAKE AND OUTPUT SHEET

Patient Name A. SPARKHILSON

Date 10-11-82

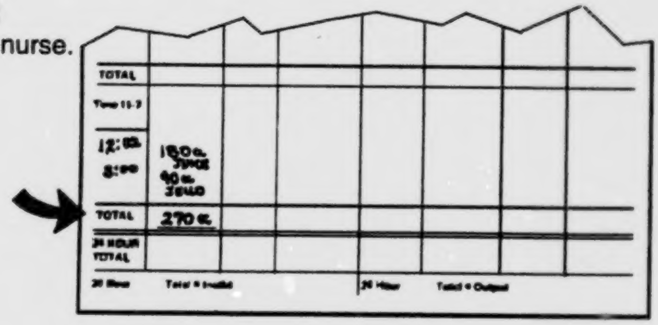
Room #10

INTAKE				OUTPUT			
				URINE		GASTRIC	
Time 7-3	BY MOUTH	TUBE	PARENTERAL	VOIDED	CATHETER	EMESIS	SUCTION
TOTAL							
Time 3-11							
3:00	180 ml. Broth 90 ml. Tea						

7. Wash your hands.

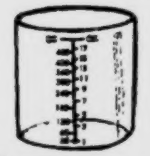
8. Record observations and report anything unusual to the charge nurse.

NOTE: Total is recorded at the end of each shift.

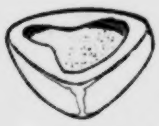

TOTAL
Time 11-7
12:00
8:00
180cc. Juice
90cc. Jello
TOTAL
270cc.
24 HOUR TOTAL
Total = Intake
Total = Output

H. Steps of Procedure for Measuring and Recording Fluid Output

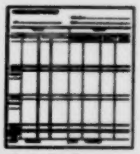
1. Assemble equipment.



☐ Graduate

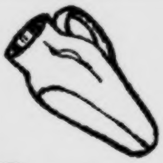


☐ Bed Pan



☐ Intake/ Output Sheet

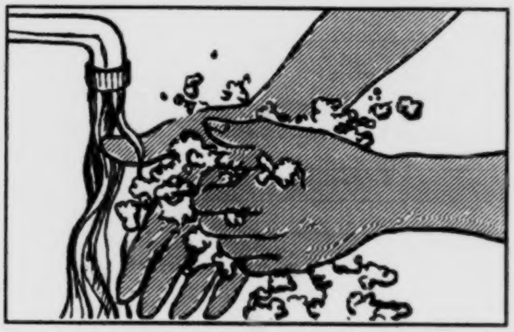
☐ Gloves



☐ Urinal

☐ Pen

2. Wash hands. Put on gloves.



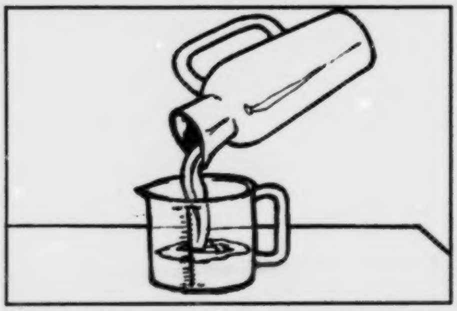
3. Identify and greet patient.

4. Identify yourself and tell patient what you plan to do.

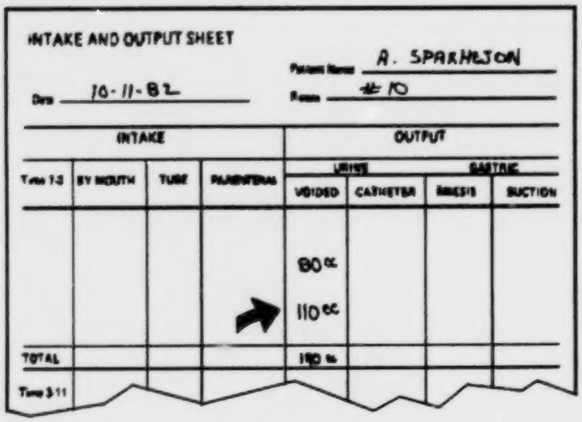
5. Pour the urine from the bedpan or urinal into a graduate in the bathroom or dirty utility room.

6. Place the graduate on a flat surface for accuracy in measurement.

7. At eye level, carefully look at the level of urine.



8. Record this amount on the output side of the Intake and Output sheet. All liquid output should be recorded. Along with urine, output includes vomitus, perspiration, drainage from wound, and liquid stool.



INTAKE AND OUTPUT SHEET

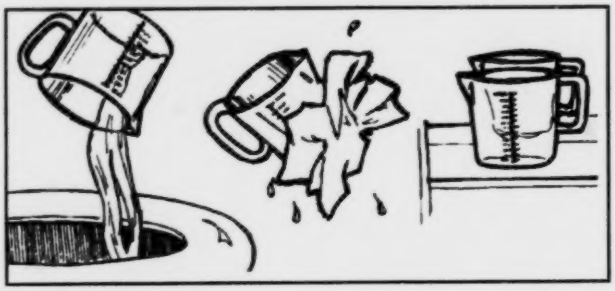
Patient Name A. SPARKHEJON

Date 10-11-82

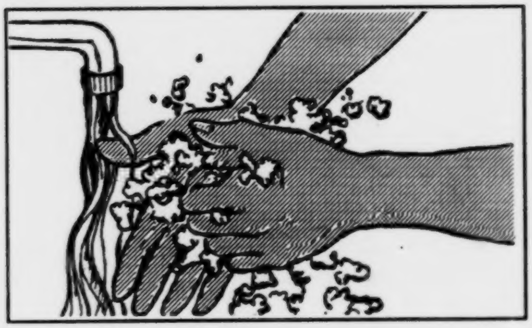
Room #10

INTAKE				OUTPUT			
				URINE		GASTRIC	
Time 7-3	BY MOUTH	TUBE	PARENTERAL	VOIDED	CATHETER	EMESIS	SUCTION
				80 cc 110 cc			
TOTAL				190 cc			
Time 3-11							

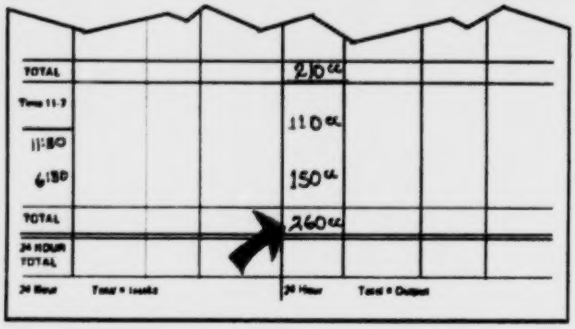
9. Empty urine into toilet. Rinse and dry container. Clean according to facility policy.



10. Remove and dispose of gloves and wash your hands.



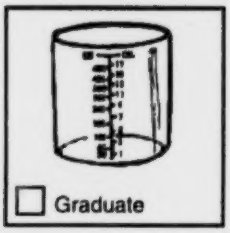
11. Record observations and report anything unusual to the charge nurse.


TOTAL
210cc
Time 11-7
11:30
110cc
6:30
150cc
TOTAL
260cc
24 HOUR TOTAL
24 Hour
Total = Intake
24 Hour
Total = Output

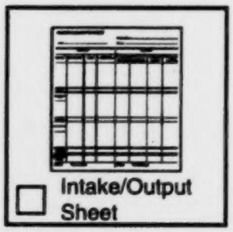
NOTE: Total is recorded at end of each shift.

I. Steps of Procedure for Emptying and Measuring Urine from an Indwelling Catheter

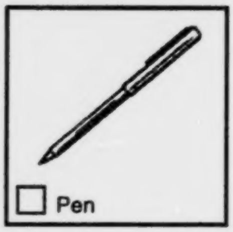
1. Assemble equipment.


☐ Graduate

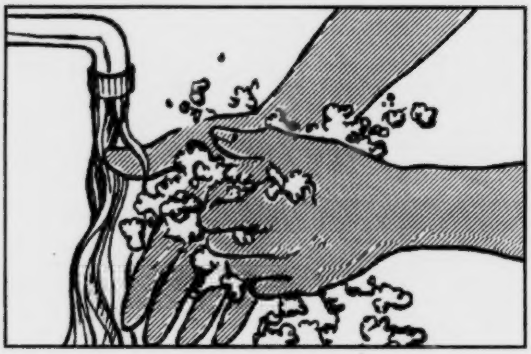
☐ Alcohol Swabs


☐ Intake/Output Sheet

☐ Gloves


☐ Pen

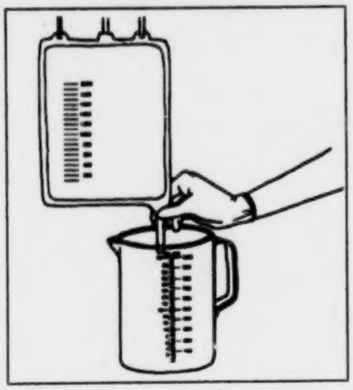
2. Wash hands. Put on gloves.



3. Identify and greet patient.

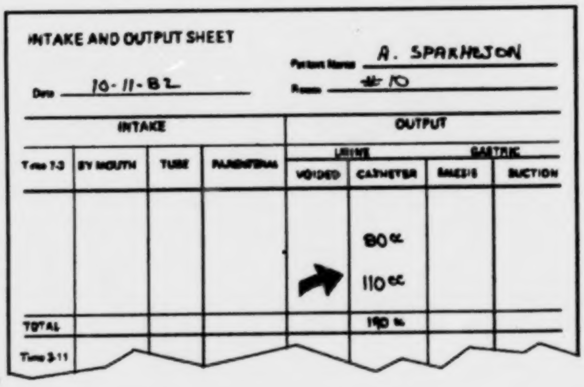
4. Identify yourself and tell patient what you plan to do.

5. Open the drain at the bottom of the plastic urine bag and let the urine run into the graduate. Close the drain, wipe drain with alcohol swab, and replace drain in the holder on the bag.



6. Measure the amount of urinary output.

7. Record the amount immediately on the output side of the intake and output sheet.



INTAKE AND OUTPUT SHEET

Patient Name A. SPARKHEJON

Date 10-11-82

Room #10

INTAKE				OUTPUT			
				URINE		GASTRIC	
Time 7-3	BY MOUTH	TUBE	PARENTERAL	VOIDED	CATHETER	EMESIS	SUCTION
					80 cc 110 cc		
TOTAL					190 cc		
Time 3-11							

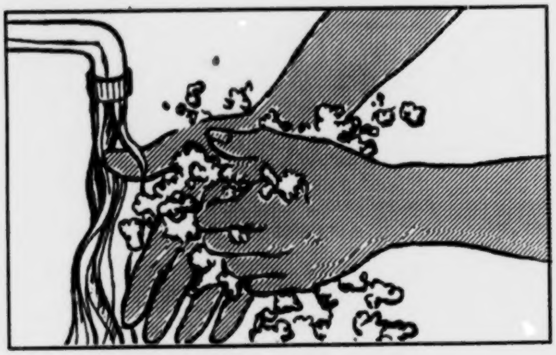
8. Wash and rinse the graduate and put it in its proper place.

9. Remove and dispose of gloves. Wash your hands.

10. Record observations and report anything unusual to the charge nurse.

J. Steps of Procedure for Distributing Drinking Water

1. Wash your hands.



2. Check with charge nurse to identify patients who cannot have water.

3. Check with care plan to identify which patients do not care for or are not allowed ice or can have nothing by mouth (NPO).

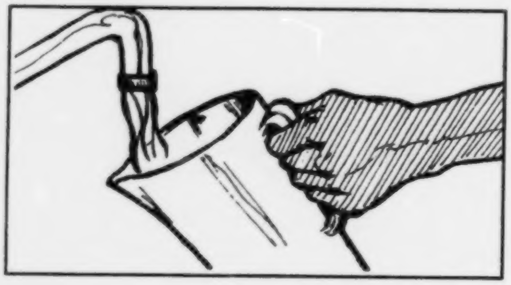
4. Collect pitchers, cups, and trays from bedside of patients and place on cart or tray.

5. Take cart or tray of equipment to dietary department.

6. Obtain clean pitchers and cups.

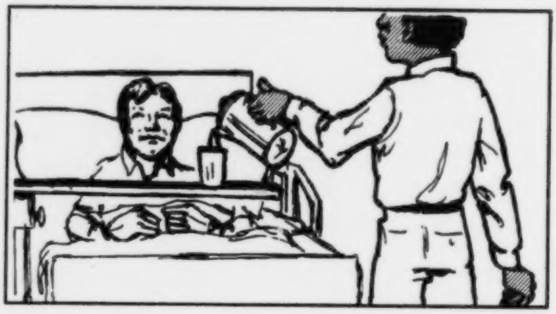
7. For patients allowed ice, fill pitchers one third full with ice; use ice tongs or a large spoon to handle ice.

8. Add water to fill pitchers.



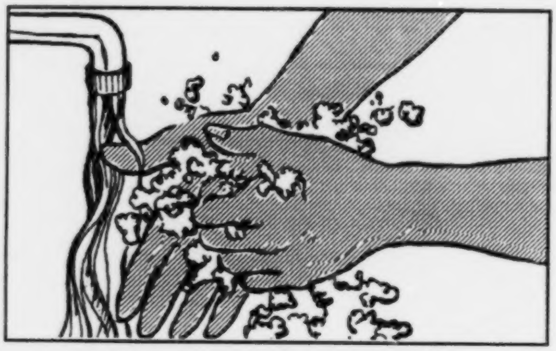
9. Return pitchers promptly to patients' bedside tables.

10. Offer fresh cup of water to patient.



11. Return equipment to proper place or as directed.

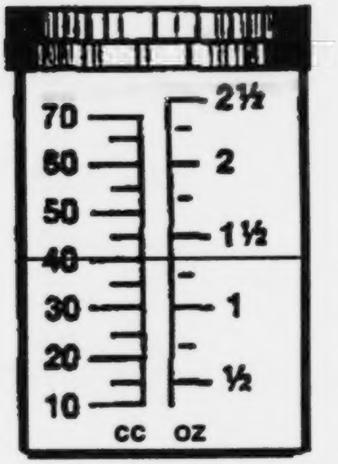
12. Wash your hands.



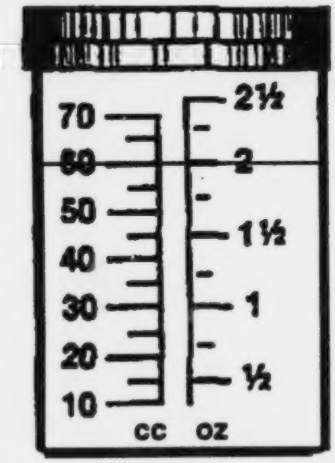
13. Record observations and report anything unusual to the charge nurse.

Measuring Intake and Output
Skill Sheet 1

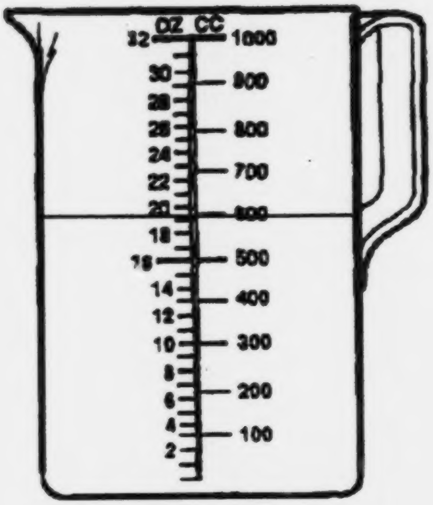
Directions: Look at the lines marked on the containers below. Identify the total amount that is shown and record it using the blank space provided. In some cases you will be asked to record both oz and cc. Remember 1 oz equals 30 cc.


70
60
50
40
30
20
10
2½
2
1½
1
½
cc
oz

1. ____________________cc

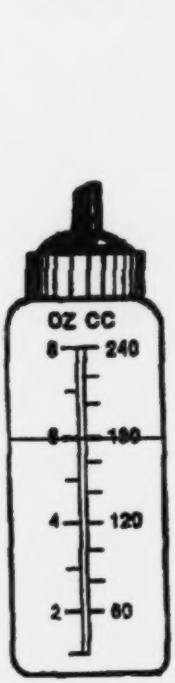

70
60
50
40
30
20
10
2½
2
1½
1
½
cc
oz

2. ____________________cc

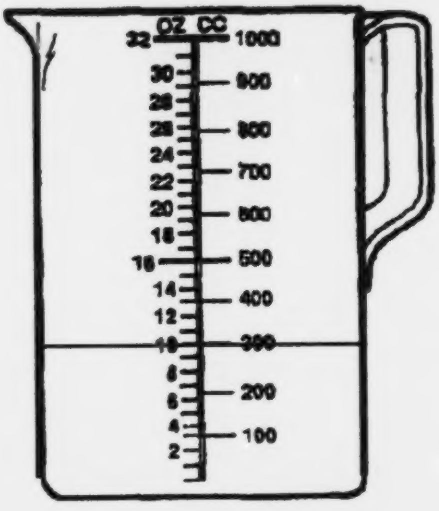

oz cc
32
30
28
26
24
22
20
18
16
14
12
10
8
6
4
2
1000
900
800
700
600
500
400
300
200
100

3. ____________________oz

____________________cc

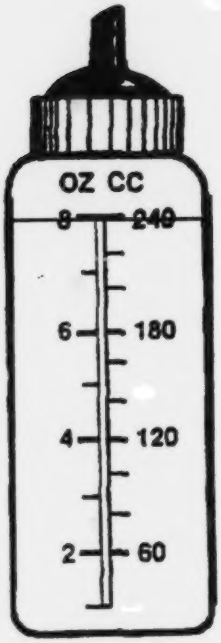

oz cc
8
240
6
180
4
120
2
60

4. ________________oz

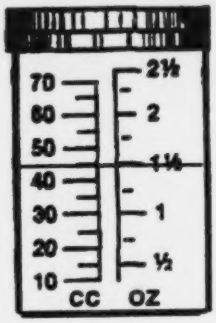

oz cc
32
30
28
26
24
22
20
18
16
14
12
10
8
6
4
2
1000
900
800
700
600
500
400
300
200
100

5. ____________________oz

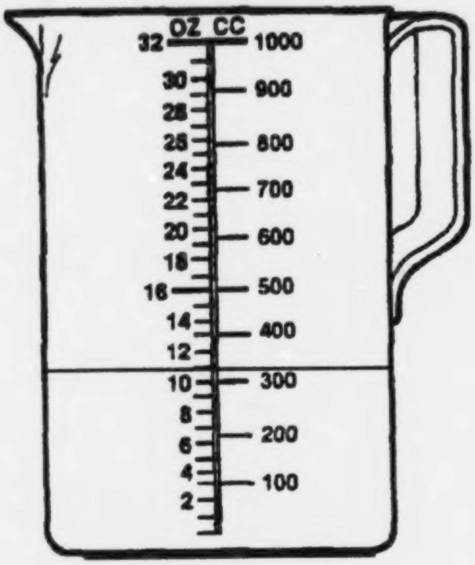
____________________cc


OZ CC
8 240
6 180
4 120
2 60

6. ____________ oz

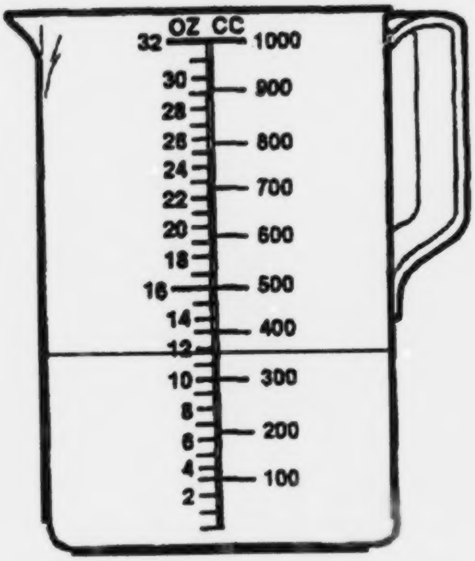

70
60
50
40
30
20
10
CC
2½
2
1½
1
½
OZ

7. ____________ oz

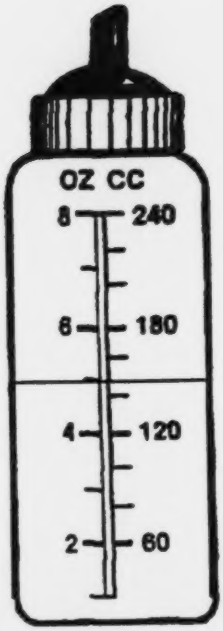

OZ CC
32 1000
30 900
28
26 800
24 700
22
20 600
18
16 500
14 400
12
10 300
8
6 200
4 100
2

8. ____________ oz

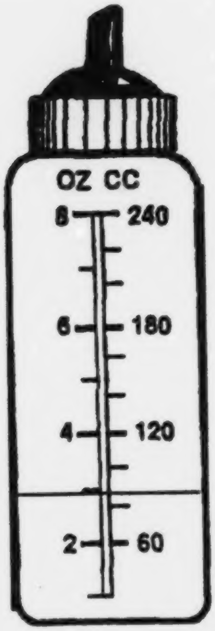
____________ cc


OZ CC
32 1000
30 900
28
26 800
24 700
22
20 600
18
16 500
14 400
12
10 300
8
6 200
4 100
2

11. ____________ oz


OZ CC
8 240
6 180
4 120
2 60

9. ____________ oz


OZ CC
8 240
6 180
4 120
2 60

10. ____________ oz

Measuring Intake and Output
Skill Sheet 2

Directions: Answer the questions below. Use the space provided for your calculations.

1. If a cup holds 12 oz and a patient drinks exactly half of the liquid, the patient drank ___________ oz of liquid.

2. If a soup bowl holds 120 cc and a patient eats exactly half the soup, the patient ate only ___________ cc of soup.

3. Mrs. Cagney is limited to 600 cc of liquid today for lunch. Add up the following amounts and identify which one is the amount she can have.

a.	Ice Cream (8 oz.)	240 cc	b.	Ice Cream (6 oz.)	180 cc
	Milk (6 oz.)	180 cc		Soup (8 oz.)	240 cc
	Juice (4 oz.)	120 cc		Milk (8 oz.)	240 cc
	TOTAL			TOTAL	

4. Record the following information on the I&O sheet provided. Put information in the proper column. Compute the intake and output.

Date - May 11
Name - Ethan Hawk
Room - 255
Method of administration - Oral

7:30 a.m.	Urine	400 cc
8:00 a.m.	Grape juice	80 cc
	Milk	130 cc
	Coffee	90 cc
9:30 a.m.	Water	180 cc
12:00 (noon)	Tea	100 cc
	Soup	200 cc
1:00 p.m.	Water	90 cc

1:15 p.m.	Urine	300 cc
2:00 p.m.	Apple juice	120 cc
2:15 p.m.	Vomitus	90 cc
3:20 p.m.	Tea	130 cc
5:00 p.m.	Orange juice	50 cc
5:30 p.m.	Urine	400 cc
6:30 p.m.	Water	90 cc
8:45 p.m	Ginger ale	150 cc
9:00 p.m.	Urine	360 cc
10:00 p.m.	Water	120 cc
10:15 p.m.	Urine	300 cc

FLUID INTAKE & OUTPUT RECORD

Name ______________________ Room __________

INTAKE					OUTPUT			
Date	Time	Meth./ Admin.	Solution	Amt. Rec'd	Time	Urine Amt.	OTHERS	
							Kind	Amt.
TOTAL					TOTAL			

Intake and Output
Written Evaluation

Match terms in Column A with definitions in Column B.

Column A	Column B
_____ 1. Dehydration	a. Excessive perspiration
_____ 2. Diaphoresis	b. A condition in which the body has less than the normal amount of fluid
_____ 3. Graduate	c. A measuring cup marked along its side to show various amounts so that material placed in the cup can be measured accurately; the marks are called calibrations
_____ 4. Emesis	d. Vomitus

Circle the letter that corresponds to the best answer.

5. Fluids may be administered in the following way(s):

   a. Intravenously
   b. Orally
   c. Nasogastric tube
   d. All of the above

6. Intake and Output are totaled:

   a. At the end of each shift.
   b. At the end of the 24-hour period.
   c. Each afternoon.
   d. A&B

7. The health care assistant checks and records liquid intake:

   a. After meals only.
   b. Between meals.
   c. Mornings and afternoons only.
   d. Before lunch is served.

8. The health care assistant would measure _______________ as liquid output from a patient.

   a. Vomitus
   b. Soda
   c. Water
   d. Pudding

9. Place a check beside the foods which must be measured for oral intake:

_____ a. water

_____ b. ice cream

_____ c. watermelon

_____ d. orange

_____ e. tea

_____ f. juice

_____ g. soup

_____ h. apples

10. Convert the following ounces to cubic centimeters or milliliters and show your work. (Remember: 1 oz equals 30 cc and 1 ml equals 1 cc.)

a. 6 oz = __________ cc

b. 4 oz = __________ ml

c. 8 oz = __________ ml

d. 12 oz = __________ cc

e. 35 oz = __________ cc

f. 20 oz = __________ cc

g. 15 oz = __________ ml

Measuring Intake and Output
Evaluation

______________________________ has successfully performed the following steps of procedure.
(Student)

Measuring and Recording Fluid Intake		Yes	No	Comments
1.	Assemble equipment.			
2.	Wash your hands.			
3.	Identify and greet patient.			
4.	Identify yourself and tell patient what you plan to do. **NOTE:** Tell patient he may help by recording fluid he takes by mouth.			
5.	Record intake on the Intake and Output sheet at the bedside. Intake includes the amount of liquid patient takes with meals and the amount of water and other liquids taken between meals.			
6.	Write down the time and record the amount of cc/ml.			
7.	Wash your hands.			
8.	Record observations and report anything unusual to the charge nurse. **NOTE:** Total is recorded at the end of each shift.			
Measuring and Recording Fluid Output				
1.	Assemble equipment.			
2.	Wash your hands. Put on gloves.			
3.	Identify and greet patient.			
4.	Identify yourself and tell patient what you plan to do.			
5.	Pour the urine from the bedpan or urinal into a graduate in the bathroom or dirty utility room.			
6.	Place the graduate on a flat surface for accuracy in measurement.			
7.	At eye level, carefully look at the level of urine.			
8.	Record this amount on the output side of the Intake and Output sheet. All liquid output should be recorded. Along with urine, output includes vomitus, perspiration, drainage from wound, and liquid stool.			
9.	Empty urine into toilet. Rinse and dry container. Clean according to facility policy.			
10.	Remove and dispose of gloves and wash your hands.			
11.	Record observations and report anything unusual to the charge nurse. **NOTE:** Total is recorded at end of each shift.			

Emptying and Measuring Urine from an Indwelling Catheter		Yes	No	Comments
1.	Assemble equipment.			
2.	Wash your hands. Put on gloves.			
3.	Identify and greet patient.			
4.	Identify yourself and tell patient what you plan to do.			
5.	Open the drain at the bottom of the plastic urine bag and let the urine run into the graduate. Close the drain, wipe drain with an alcohol swab, and replace drain in the holder on the bag.			
6.	Measure the amount of urinary output.			
7.	Record the amount immediately on the output side of the intake and output sheet.			
8.	Wash and rinse the graduate and put it in its proper place.			
9.	Remove and dispose of gloves. Wash your hands.			
10.	Record observations and report anything unusual to the charge nurse.			
Distributing Drinking Water				
1.	Wash your hands.			
2.	Check with charge nurse to identify patients who cannot have water.			
3.	Check with care plan to identify which patients do not care for or are not allowed ice or can have nothing by mouth (NPO).			
4.	Collect pitchers, cups, and trays from bedside of patients and place on cart or tray.			
5.	Take cart or tray of equipment to dietary department.			
6.	Obtain clean pitchers and cups.			
7.	For patients allowed ice, fill pitchers one third full with ice; use ice tongs or a large spoon to handle ice.			
8.	Add water to fill pitchers.			
9.	Return pitchers promptly to patients' bedside tables.			
10.	Offer fresh cup of water to patient.			
11.	Return equipment to proper place or as directed.			
12.	Wash your hands.			
13.	Record observations and report anything unusual to the charge nurse.			

Student's Signature/Date

Instructor's Signature/Date

Assist Patient in Using the Bedpan and Urinal

Unit Objective

After completing this unit, you should be able to assist a patient in using a urinal or bedpan, and place a helpless patient on a bedpan.

Specific Objectives

After completing this unit, you should be able to:

A. Match terms in this unit with their correct definitions.

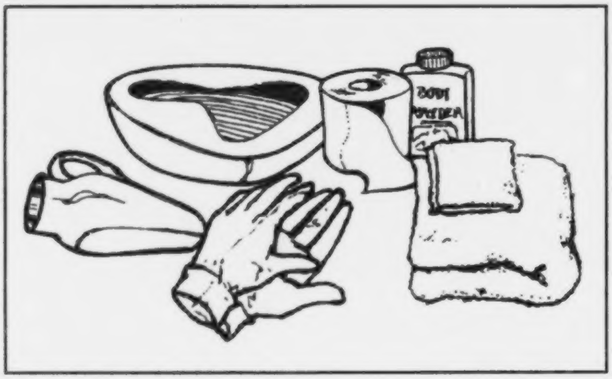
B. Assist a patient in using a urinal according to steps of procedure.

C. Assist a patient in using a bedpan according to steps of procedure.

D. Place a helpless patient on a bedpan according to steps of procedure.

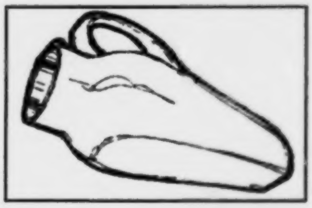
Introduction

If a patient is unable to get out of bed, the health care assistant will need to provide a bedpan and urinal. When not in use, these items should be kept clean and covered in a bedside cabinet.

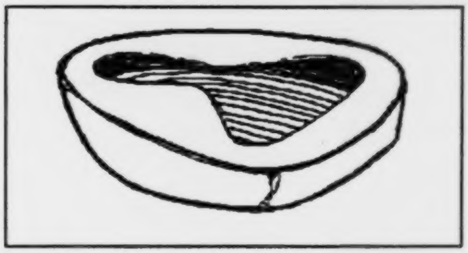


A. Terms

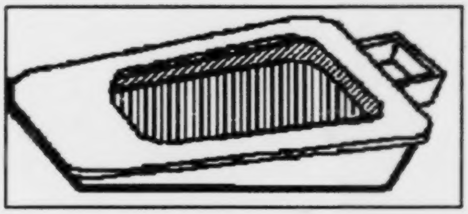
Urinal - a container for male patients to urinate into if they cannot get out of bed or if they are on intake and output



Bedpan - pan used for having a bowel movement or for urinating when female patient is confined to bed



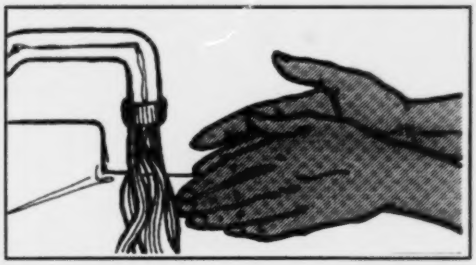
Fracture bedpan - pan used for patients in traction or for those who have a cast; the smaller end is placed under the buttocks



Call light - a signal light attached to a patient's bed which allows patient to call for help by pressing the call button

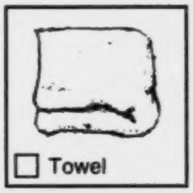
B. Steps of Procedure For Assisting Patient in Using a Urinal

1. Wash hands. Put on gloves.



2. Assemble equipment.

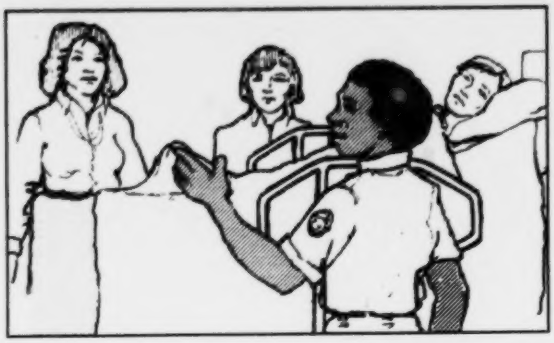
☐ Gloves



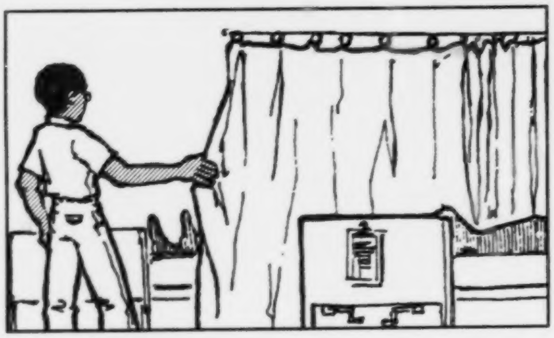
☐ Towel

☐ Urinal

3. Identify and greet patient. Identify self. Explain what you are going to do. Ask visitors to step out of the room.

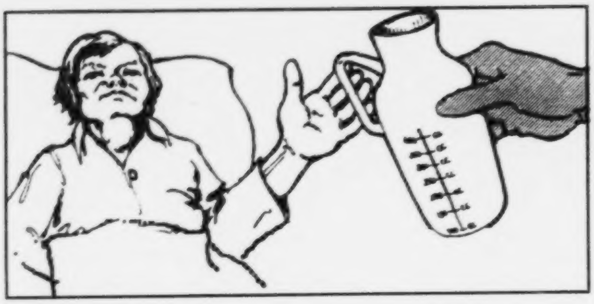


4. Provide privacy. Pull curtain around bed.



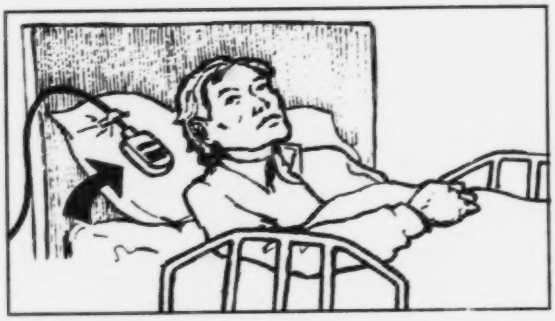
5. Turn back bedding, except for top sheet. Expose the peri area.

6. Offer clean urinal to patient.



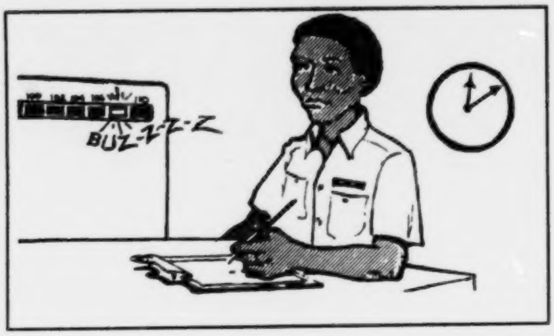
NOTE: If patient can't do so himself, place his penis in the urinal and lay the urinal between his legs. The flat edge should be lying on the bed to keep urine from spilling out.

7. Place call light where patient can reach it. Ask patient to press the call light when finished.

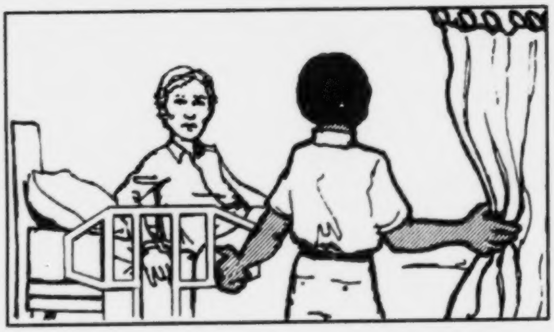


8. Remove and discard gloves in appropriate container. Wash your hands.

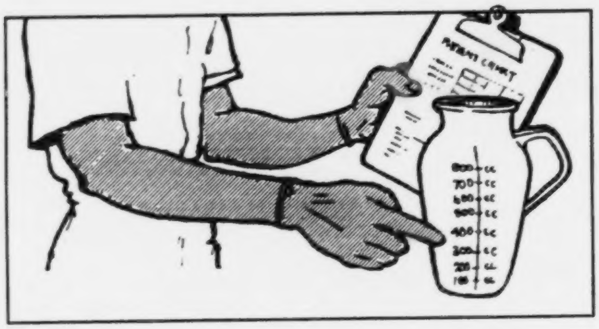
9. Leave room. Return within five minutes unless patient calls before.



10. Wash hands and put on clean gloves. Remove and cover urinal. Open curtain.

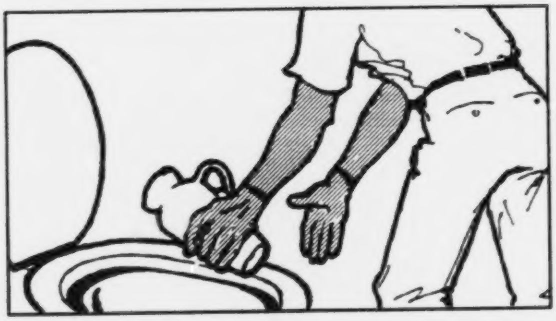


11. Take urinal to bathroom. Look at contents of urinal. Note color, amount and clearness of urine.


PATIENT CHART
800 cc
700 cc
600 cc
500 cc
400 cc
300 cc
200 cc
100 cc

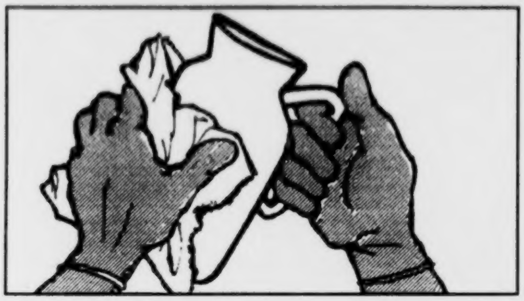
NOTE: Report to nurse or supervisor if any unusual observation is made, such as unusual color or if urine is not clear.

12. Measure urine if patient is on intake and output and empty urinal into toilet.

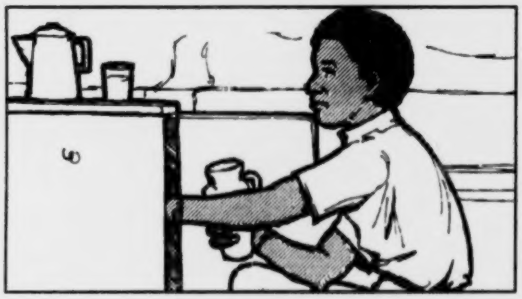


13. Rinse urinal with cold water and empty into toilet again.

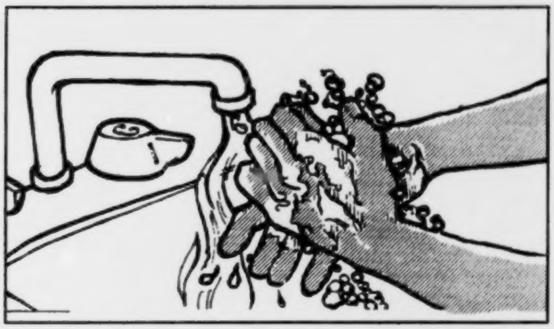
14. Dry outside of urinal with paper towel. Throw paper towel in bathroom waste can.



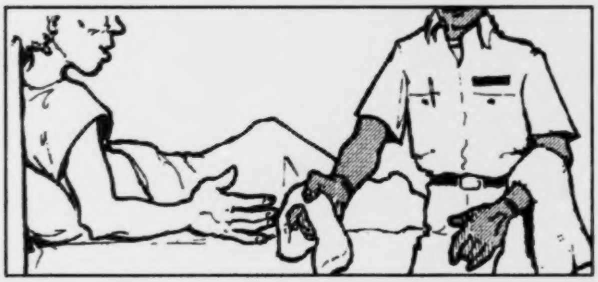
15. Place clean urinal in bedside stand.



16. Remove and discard gloves in appropriate container. Wash your hands.



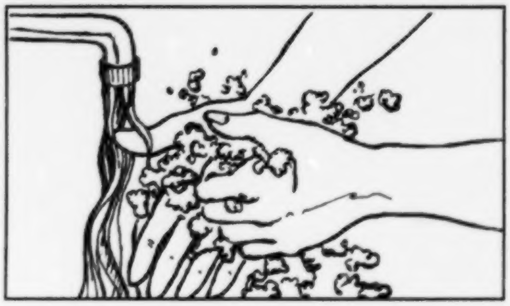
17. Give patient a wet washcloth for handwashing. Give patient a towel to dry hands. Make patient comfortable.



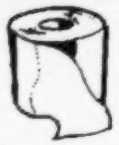
18. Record observations and report anything unusual to the charge nurse.

C. Steps of Procedure for Assisting a Patient in Using a Bedpan

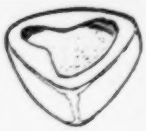
1. Wash hands. Put on gloves.



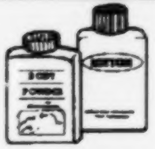
2. Assemble equipment.



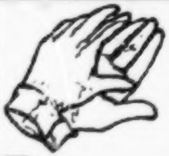
☐ Toilet paper



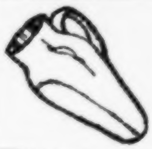
☐ Bedpan



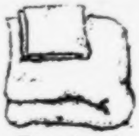
☐ Powder, lotion



☐ Gloves

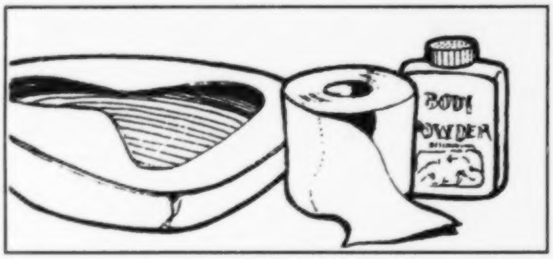


☐ Urinal



☐ Towel and washcloth

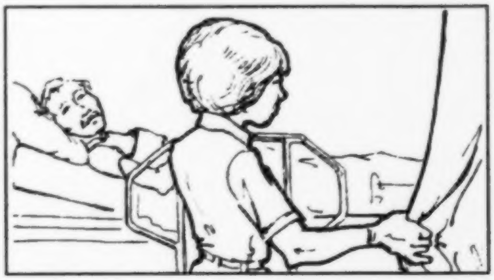
3. Bring clean bedpan, a roll of toilet paper, and powder to bedside.



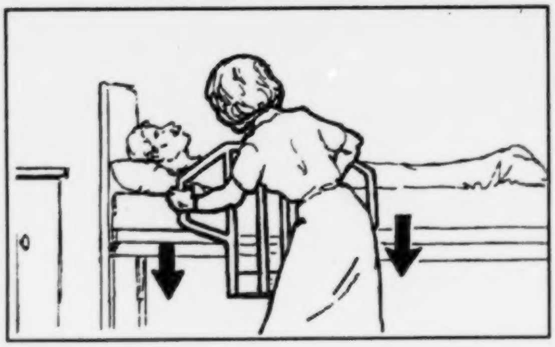
4. Identify and greet patient. Identify self.

5. Explain what you are going to do.

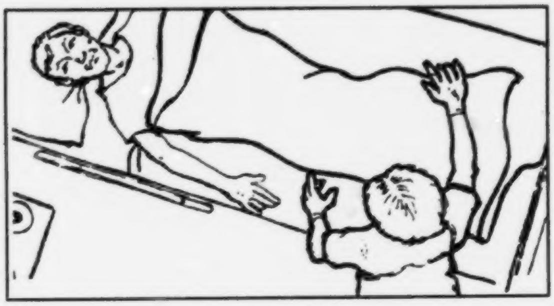
6. Provide privacy. Pull curtain around bed.



7. Lower side rail on bed.

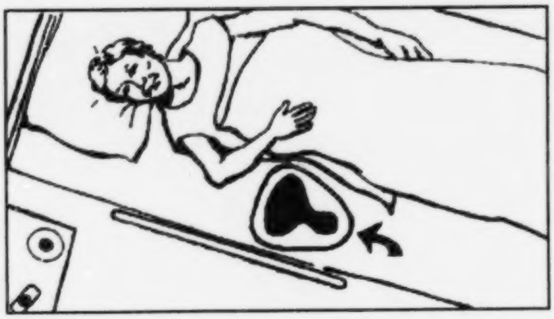


8. Fold covers to side, but keep patient covered.



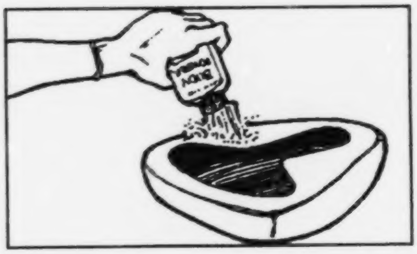
9. Place bedpan on bed beside patient.

NOTE: Be sure open end (smaller end) of bedpan is toward foot of bed. When using fracture pan the end with the handle should face the foot of the bed.

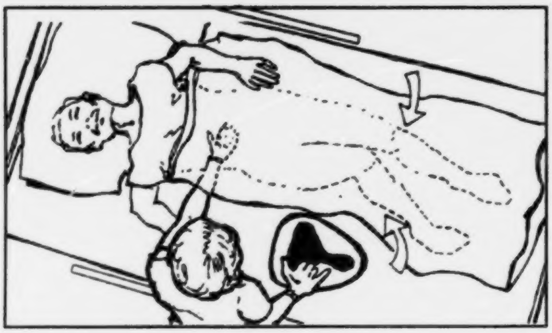


10. Lightly sprinkle powder on rim of bedpan to prevent sticking.

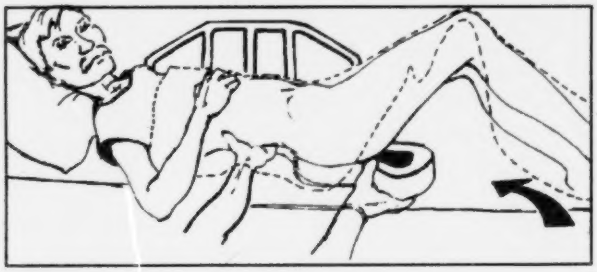
NOTE: Do not put powder on bedpan if a specimen is to be collected.



11. Have patient bend his knees. Slide one hand under patient's lower back. Help patient to lift hips if patient has pajamas or underwear on, lower it to his/her knees.

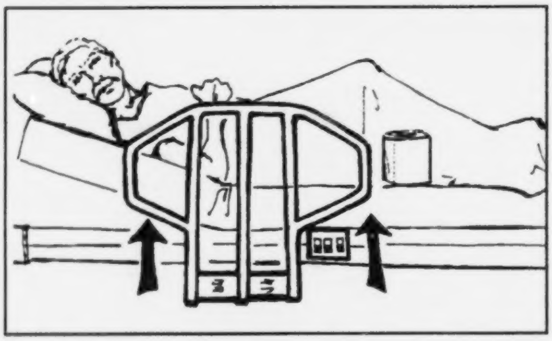


12. With other hand, slide bedpan under center of patient's buttocks. Keep open end of bedpan toward feet.

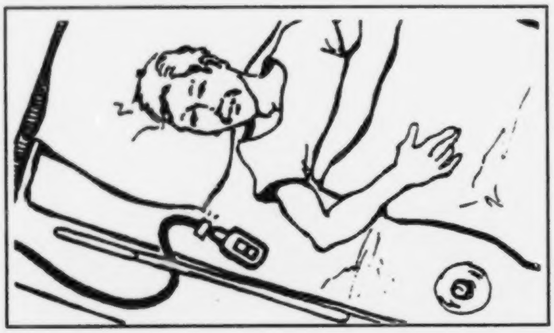


NOTE: Be sure pan is completely under patient's buttocks to avoid soiling bed.

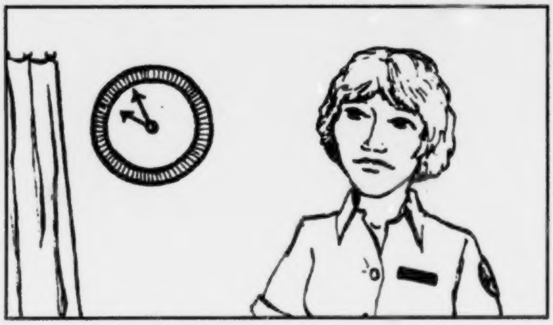
13. Raise head of bed, unless patient has been told to lie flat. Place toilet paper next to patient. Pull up side rails if appropriate.



14. Place call light where it can be easily reached. Tell patient to press call light when finished.



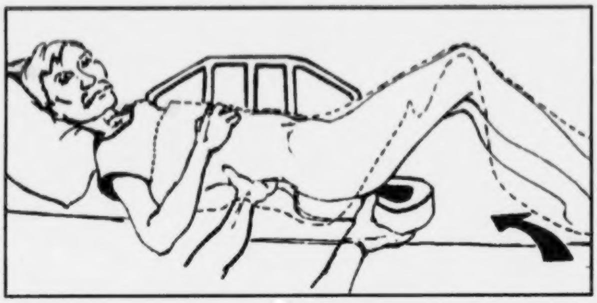
15. Leave patient alone. Remove and discard gloves in appropriate container. Wash hands. Check on patient within five minutes, unless patient calls before.



NOTE: Do not leave patient on bedpan for over ten minutes. It may lead to extreme discomfort and result in skin breakdown.

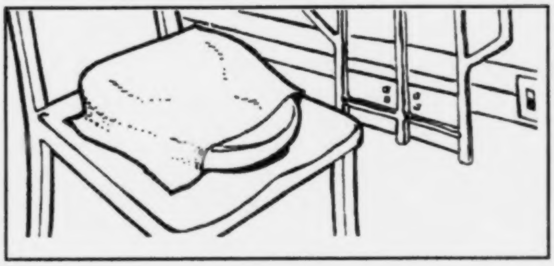
16. Wash hands and put on clean gloves. Lower side rail and lower head of bed, if allowed.

17. Slip one hand under patient's back to help patient lift hips. With other hand, slide bedpan gently from under patient.



NOTE: Slide bedpan gently so contents do not spill. If it will not slide easily, press call light for help.

18. Place bedpan on chair beside bed and cover with bedpan cover.

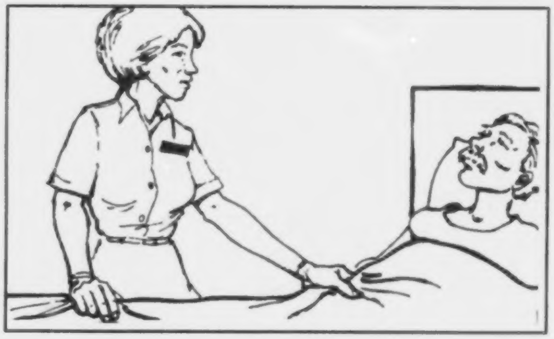


19. Have patient turn on side, cleanse patient with toilet paper, if patient is unable to do it. Wipe perineal area with toilet paper from front to back. Place soiled toilet paper in bedpan.

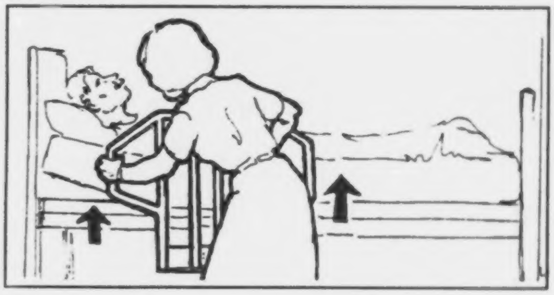
NOTE: Always cleanse female from front to back. If patient is on intake and output, dispose of toilet paper in toilet. Otherwise, place toilet paper in bedpan.

20. Wash area with washcloth and dry with a towel.

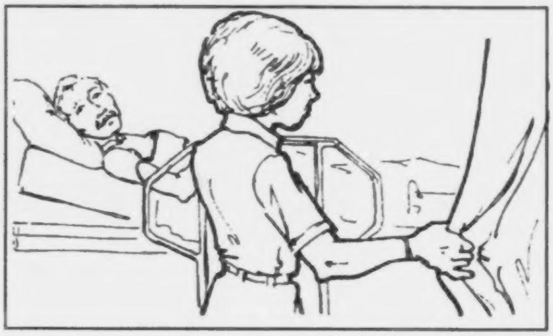
21. Straighten sheets.



22. Readjust bed and pull up side rails if appropriate.

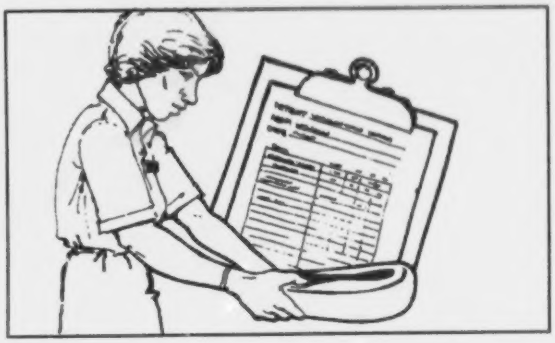


23. Open curtain.

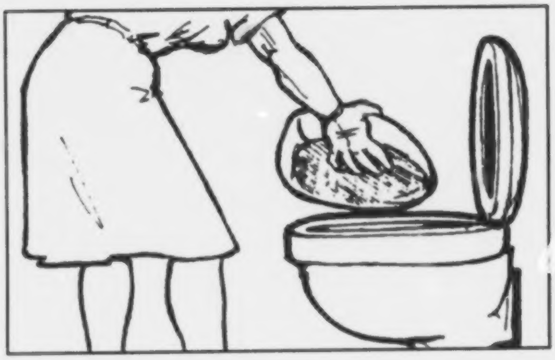


24. Take bedpan into bathroom. Look at contents. Note color, amount, and consistency of stool or urine and record. Measure urine if patient is on intake and output.

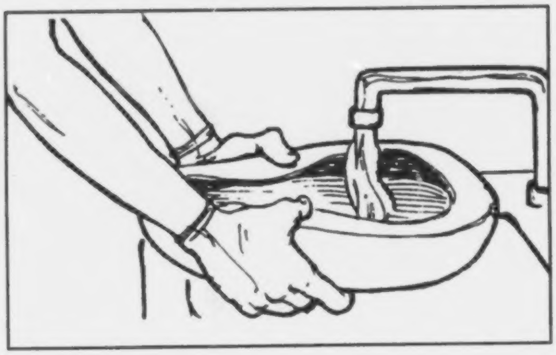
NOTE: Report to nurse or supervisor if stool is black, chalky, or red. Report if it is runny or very hard.



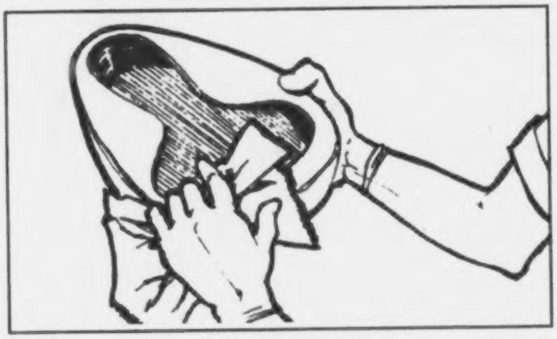
25. Empty bedpan into toilet.



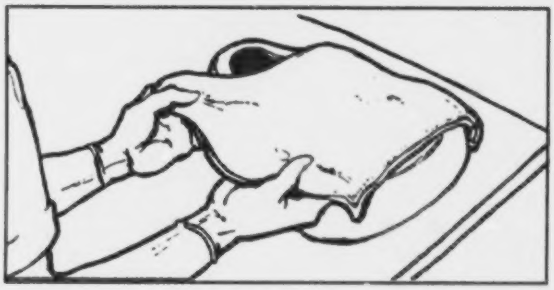
26. Rinse bedpan until clean with cold water. Empty into toilet.



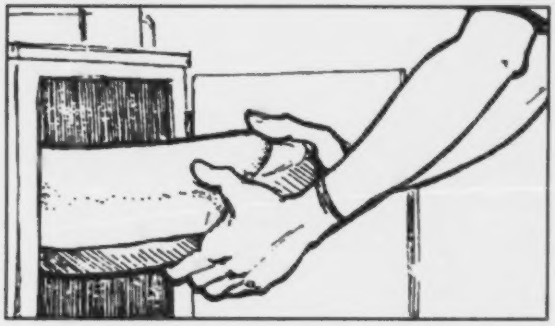
27. Dry outside bedpan with paper towels. Throw paper towels in bathroom waste can.



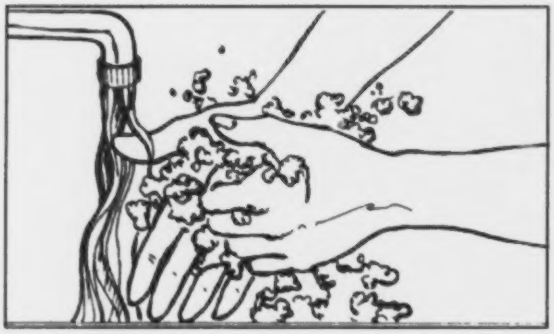
28. Cover bedpan with bedpan cover.



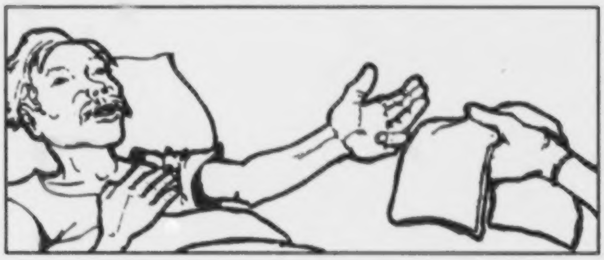
29. Place bedpan in bedside stand.



30. Remove and discard gloves in appropriate container. Wash your hands.



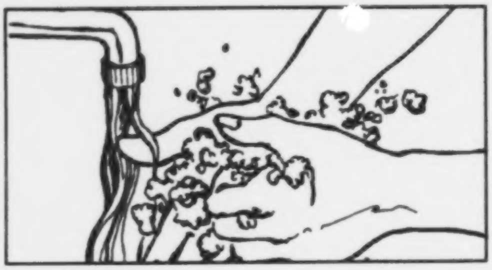
31. Give patient a wet washcloth to wash hands and a towel to dry them.



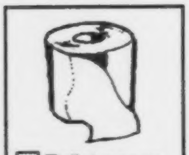
32. Record observations and report anything unusual to the charge nurse.

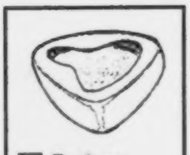
D. Steps of Procedure for Placing a Helpless Patient on a Bedpan

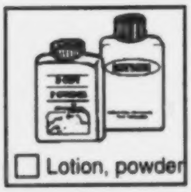
1. Wash hands. Put on gloves.

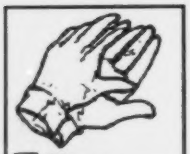


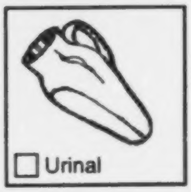
2. Assemble equipment.

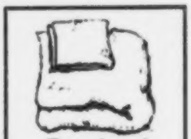

☐ Toilet paper


☐ Bedpan


☐ Lotion, powder


☐ Gloves


☐ Urinal


☐ Towel and washcloth

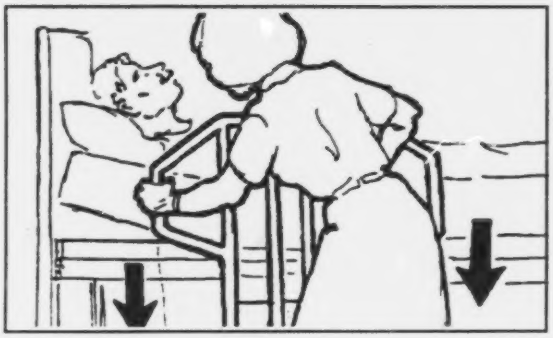
3. Identify and greet patient. Identify self. Explain what you are going to do.

4. Ask for another caregiver to help you.

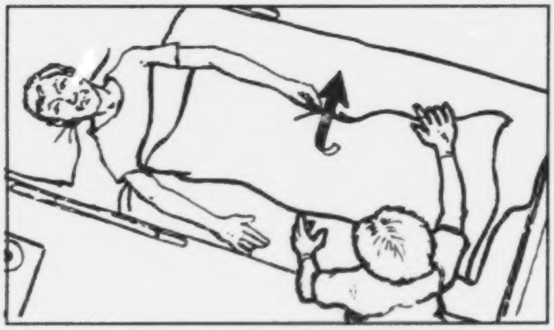
NOTE: Always have all your equipment ready before calling for someone to help.

5. Provide privacy. Pull curtain around bed.

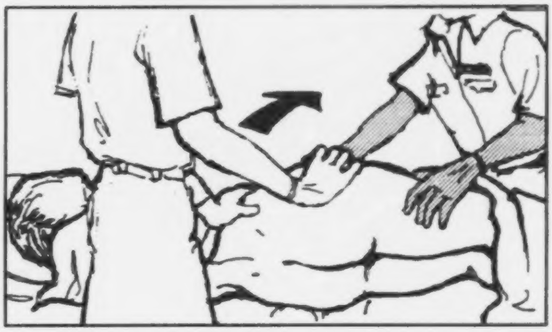
6. Lower side rail on bed, both if necessary.



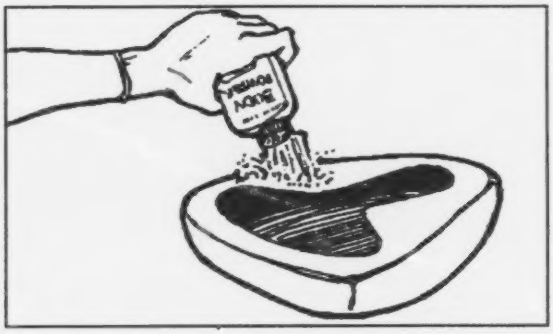
7. Fold covers to side, but keep patient covered.



8. Turn patient on side.



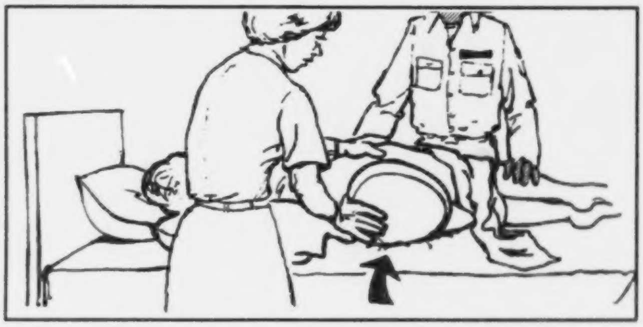
9. Lightly sprinkle powder on rim of bedpan to prevent sticking.



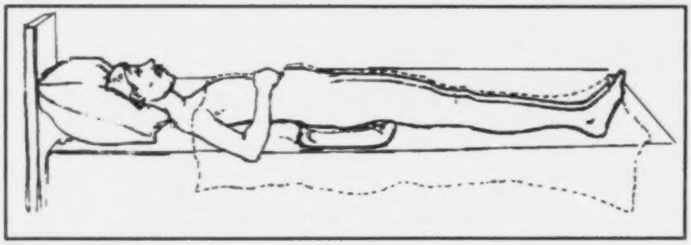
NOTE: Do not put powder on bedpan if a specimen is to be collected.

10. Place bedpan against patient's buttocks.

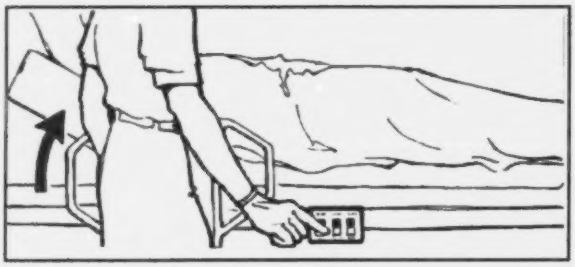
NOTE: When using fracture pan the end with the handle should face the foot of the bed.



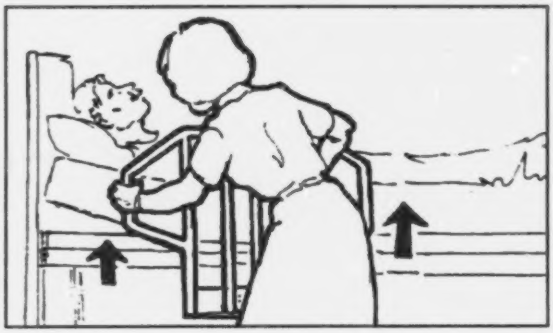
11. Roll patient back over.



12. Raise head of bed, unless patient has been told to lie flat.

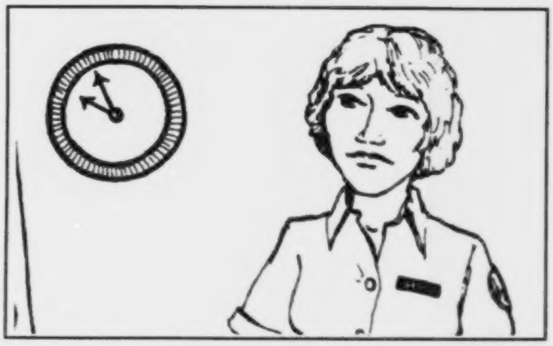


13. Pull side rails up if appropriate.



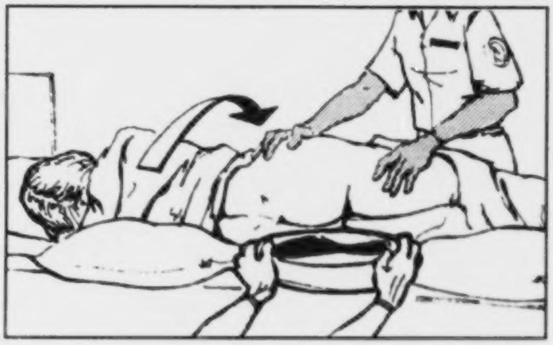
14. Step outside curtain.

15. Remove and discard gloves in appropriate container. Wash hands. Check on patient within five minutes, unless patient calls before.



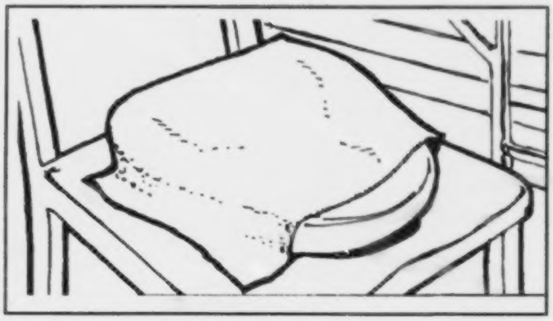
16. Wash hands. Put on clean gloves.

17. When patient is finished, lower head of bed, if allowed, and hold bedpan flat on bed while helper rolls patient onto side.

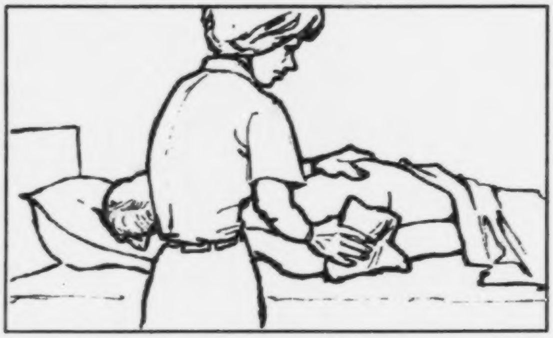


NOTE: If removing bedpan without help, hold bedpan with one hand and roll patient off pan with the other hand.

18. Remove bedpan and set on chair beside bed. Cover it with bedpan cover.



19. Cleanse peri area with toilet paper.

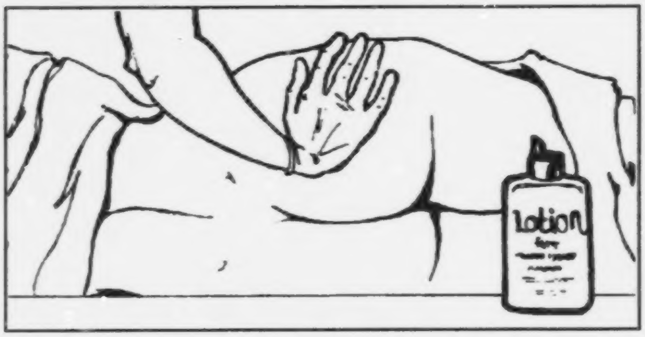


NOTE: Always cleanse female from front to back. If patient is on intake and output, dispose of toilet paper in toilet. Otherwise, place toilet paper in bedpan.

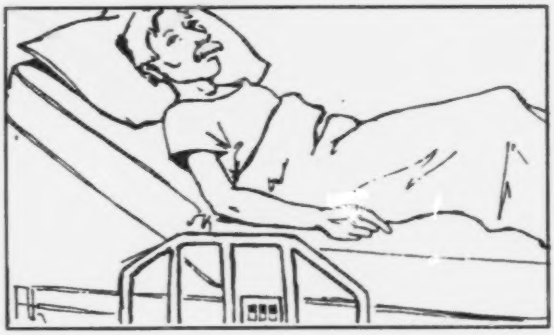
20. Gently cleanse peri area and buttocks with damp washcloth. Wipe from front to back. Dry with towel.

CAUTION: Patients who lie in bed for a long time get skin breakdown easily. It is important to keep patient's skin clean and dry.

21. Apply lotion to buttocks.

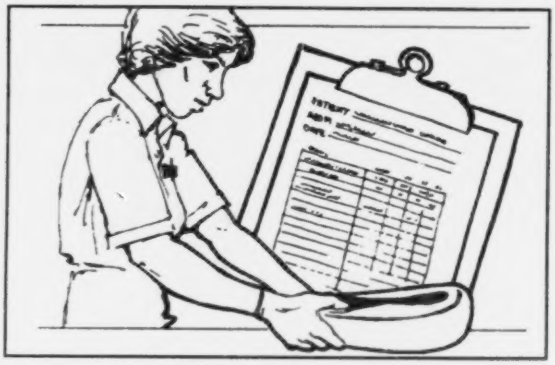


22. Turn patient to a comfortable position.



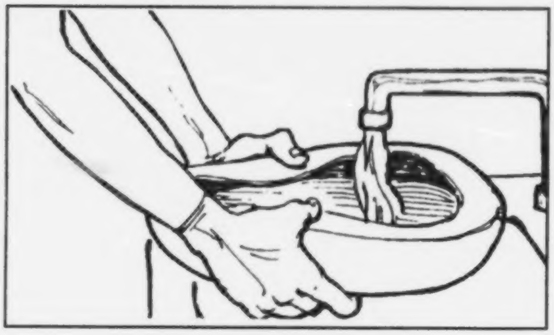
23. Pull up side rails if appropriate.

24. Take bedpan into bathroom. Look at contents. Note color, amount, and consistency of stool or urine. Measure urine if patient is on intake and output.

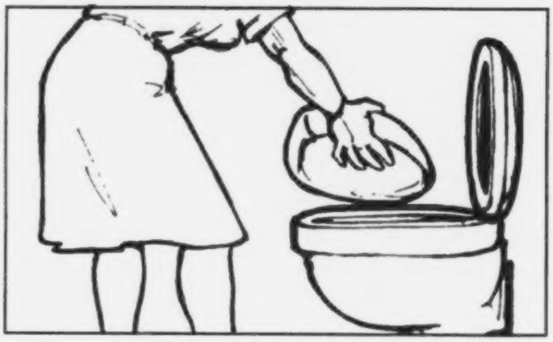


25. Empty bedpan into toilet.

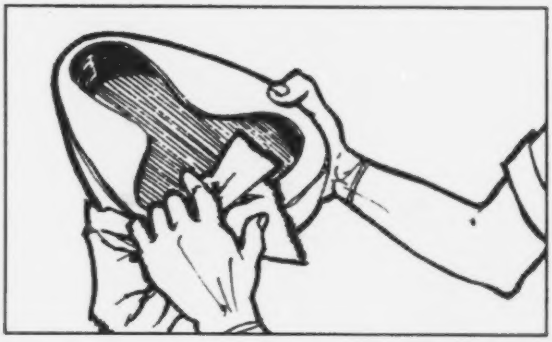
26. Rinse bedpan with cold water.



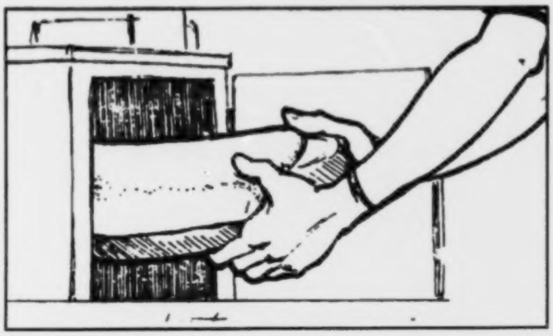
27. Empty water in toilet. Repeat until clean.



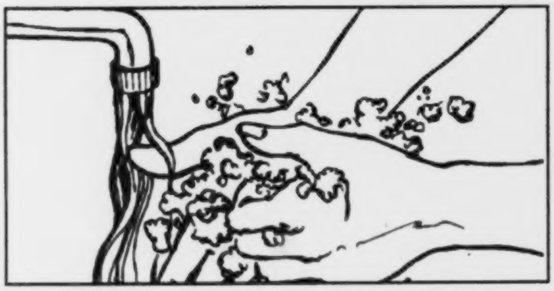
28. Dry outside of bedpan with paper towels.



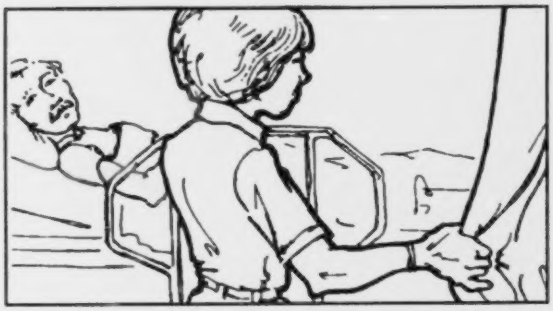
29. Cover bedpan with a towel or bedpan cover and place it in bedside stand.



30. Remove gloves and discard in appropriate container. Wash hands.



31. Open curtain.



32. Readjust bed. Straighten sheets.

33. Record observations and report anything unusual to the charge nurse.

Assist a Patient in Using a Bedpan and Urinal

Written Evaluation

Circle the letter that corresponds to the best answer.

1. If a patient is unable to place a urinal, you should:

   a. Tell the charge nurse.
   b. Place the urinal yourself.
   c. Tell the patient you don't know how to place the urinal and go get help.
   d. Tell the patient he must place urinal himself.

2. Bedpans are used for:

   a. Elimination of urine only.
   b. Elimination of bowel movement only.
   c. Elimination of both urine and bowel movement.
   d. Elimination of vomit and urine only.

3. If a patient is unable to help to get on the bedpan, you should:

   a. Get someone to help you.
   b. Tell him he must get up to the bathroom.
   c. Tell him he must get up to use a bedside commode.
   d. Tell him he must wait for the charge nurse.

Match terms in Column A with definitions in Column B.

Column A

_____ 4. Urinal

_____ 5. Bedpan

_____ 6. Fracture bedpan

_____ 7. Call light

Column B

a. A tube put into a body cavity, usually to withdraw fluid
b. A signal light attached to a patient's bed which allows patient to call for help by pressing the call light
c. A pan used for patients in traction or for those who have a cast
d. A pan used for having a bowel movement or for urinating when female patient is confined to bed
e. A container for male patients to urinate into if they cannot get out of bed or if they are on intake and output

Assist a Patient in Using a Bedpan and Urinal
Evaluation

________________________has successfully completed the following steps of procedure.
(Student)

Assisting Patient in Using a Urinal		Yes	No	Comments
1.	Wash hands. Put on gloves.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self. Explain what you are going to do. Ask visitors to step out of the room.			
4.	Provide privacy. Pull curtain around bed.			
5.	Turn back bedding, except for top sheet. Expose the peri area.			
6.	Offer clean urinal to patient. **NOTE:** If patient can't do so himself, place his penis in the urinal and lay the urinal between his legs. The flat edge should be lying on the bed to keep urine from spilling out.			
7.	Place call light where patient can reach it. Ask patient to press the call light when finished.			
8.	Remove and discard gloves in appropriate container. Wash your hands.			
9.	Leave room. Return within five minutes unless patient calls before.			
10.	Wash hands and put on clean gloves. Remove and cover urinal. Open curtain.			
11.	Take urinal to bathroom. Look at contents of urinal. Note color, amount and clearness of urine. **NOTE:** Report to nurse or supervisor if any unusual observation is made, such as unusual color or if urine is not clear.			
12.	Measure urine if patient is on intake and output and empty urinal into toilet.			
13.	Rinse urinal with cold water and empty into toilet again.			
14.	Dry outside of urinal with paper towel. Throw paper towel in bathroom waste can.			
15.	Place clean urinal in bedside stand.			
16.	Remove and discard gloves in appropriate container. Wash your hands.			
17.	Give patient a wet washcloth for handwashing. Give patient a towel to dry hands. Make patient comfortable.			
18.	Record observations and report anything unusual to the charge nurse.			

Assisting a Patient in Using a Bedpan		Yes	No	Comments
1.	Wash hands. Put on gloves.			
2.	Assemble equipment.			
3.	Bring clean bedpan, a roll of toilet paper, and powder to bedside.			
4.	Identify and greet patient. Identify self.			
5.	Explain what you are going to do.			
6.	Provide privacy. Pull curtain around bed.			
7.	Lower side rail on bed.			
8.	Fold covers to side, but keep patient covered.			
9.	Place bedpan on bed beside patient. **NOTE:** Be sure open end (smaller end) of bedpan is toward foot of bed. When using fracture pan the end with the handle should face the foot of the bed.			
10.	Lightly sprinkle powder on rim of bedpan to prevent sticking. **NOTE:** Do not put powder on bedpan if a specimen is to be collected.			
11.	Have patient bend his knees. Slide one hand under patient's lower back. Help patient to lift hips if patient has pajamas or underwear on. Lower it to his/her knees.			
12.	With other hand, slide bedpan under center of patient's buttocks. Keep open end of bedpan toward feet. **NOTE:** Be sure pan is completely under patient's buttocks to avoid soiling bed.			
13.	Raise head of bed, unless patient has been told to lie flat. Place toilet paper next to patient. Pull up side rails if appropriate.			
14.	Place call light where it can be easily reached. Tell patient to press call light when finished.			
15.	Leave patient alone. Remove and discard gloves in appropriate container. Wash hands. Check on patient within five minutes, unless patient calls before. **NOTE:** Do not leave patient on bedpan for over ten minutes. It may lead to extreme discomfort and result in skin breakdown.			
16.	Wash hands and put on clean gloves. Lower side rail and lower head of bed, if allowed.			
17.	Slip one hand under patient's back to help patient lift hips. With other hand, slide bedpan gently from under patient. **NOTE:** Slide bedpan gently so contents do not spill. If it will not slide easily, press call light for help.			
18.	Place bedpan on chair beside bed and cover with bedpan cover.			

Assisting a Patient in Using a Bedpan Cont.		**Yes**	**No**	**Comments**
19.	Have patient turn on side, cleanse patient with toilet paper, if patient is unable to do it. Wipe perineal area with toilet paper from front to back. Place soiled toilet paper in bedpan. **NOTE:** Always cleanse female from front to back. If patient is on intake and output, dispose of toilet paper in toilet. Otherwise, place toilet paper in bedpan.			
20.	Wash area with washcloth and dry with a towel.			
21.	Straighten sheets.			
22.	Readjust bed and pull up side rails if appropriate.			
23.	Open curtain.			
24.	Take bedpan into bathroom. Look at contents. Note color, amount, and consistency of stool or urine and record. Measure urine if patient is on intake and output. **NOTE:** Report to nurse or supervisor if stool is black, chalky, or red. Report if it is runny or very hard.			
25.	Empty bedpan into toilet.			
26.	Rinse bedpan until clean with cold water. Empty into toilet.			
27.	Dry outside bedpan with paper towels. Throw paper towels in bathroom waste can.			
28.	Cover bedpan with bedpan cover.			
29.	Place bedpan in bedside stand.			
30.	Remove and discard gloves in appropriate container. Wash your hands.			
31.	Give patient a wet washcloth to wash hands and a towel to dry them.			
32.	Record observations and report anything unusual to the charge nurse.			
Placing a Helpless Patient on a Bedpan				
1.	Wash hands. Put on gloves.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self. Explain what you are going to do.			
4.	Ask for another caregiver to help you. **NOTE:** Always have all your equipment ready before calling for someone to help.			
5.	Provide privacy. Pull curtain around bed.			
6.	Lower side rail on bed, both if necessary.			
7.	Fold covers to side, but keep patient covered.			
8.	Turn patient on side.			
9.	Lightly sprinkle powder on rim of bedpan to prevent sticking. **NOTE:** Do not put powder on bedpan if a specimen is to be collected.			

Placing a Helpless Patient on a Bedpan Cont.		Yes	No	Comments
10.	Place bedpan against patient's buttocks. **NOTE:** When using fracture pan the end with the handle should face the foot of the bed.			
11.	Roll patient back over.			
12.	Raise head of bed, unless patient has been told to lie flat.			
13.	Pull side rails up if appropriate.			
14.	Step outside curtain.			
15.	Remove and discard gloves in appropriate container. Wash hands. Check on patient within five minutes, unless patient calls before.			
16.	Wash hands. Put on clean gloves.			
17.	When patient is finished, lower head of bed, if allowed, and hold bedpan flat on bed while helper rolls patient onto side. **NOTE:** If removing bedpan without help, hold bedpan with one hand and roll patient off pan with the other hand.			
18.	Remove bedpan and set on chair beside bed. Cover it with bedpan cover.			
19.	Cleanse peri area with toilet paper. **NOTE:** Always cleanse female from front to back. If patient is on intake and output, dispose of toilet paper in toilet. Otherwise, place toilet paper in bedpan.			
20.	Gently cleanse peri area and buttocks with damp washcloth. Wipe from front to back. Dry with towel. **CAUTION:** Patients who lie in bed for a long time get skin breakdown easily. It is important to keep patient's skin clean and dry.			
21.	Apply lotion to buttocks.			
22.	Turn patient to a comfortable position.			
23.	Pull up side rails if appropriate.			
24.	Take bedpan into bathroom. Look at contents. Note color, amount, and consistency of stool or urine. Measure urine if patient is on intake and output.			
25.	Empty bedpan into toilet.			
26.	Rinse bedpan with cold water.			
27.	Empty water in toilet. Repeat until clean.			
28.	Dry outside of bedpan with paper towels.			
29.	Cover bedpan with a towel or bedpan cover and place it in bedside stand.			
30.	Remove gloves and discard in appropriate container. Wash hands.			
31.	Open curtain.			
32.	Readjust bed. Straighten sheets.			
33.	Record observations and report anything unusual to the charge nurse.			

Student's Signature/Date

Instructor's Signature/Date

Feeding the Patient

Unit Objective

After completing this unit, you should be able to prepare a patient for a meal and feed a helpless patient.

Specific Objectives

After completing this unit, you should be able to:

A. Match terms in this unit with their correct definitions.

B. Prepare a patient for a meal according to steps of procedure.

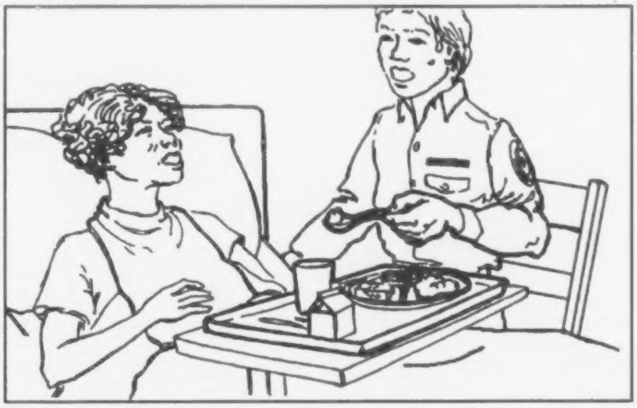
C. Feed a helpless patient according to steps of procedure.

Introduction

Some patients are helpless and have to be fed. They may be unable to use their hands or they may be too weak. It may be depressing for adults not to be able to feed themselves so encourage them to do as much for themselves as possible. Sometimes you will have to do it all.

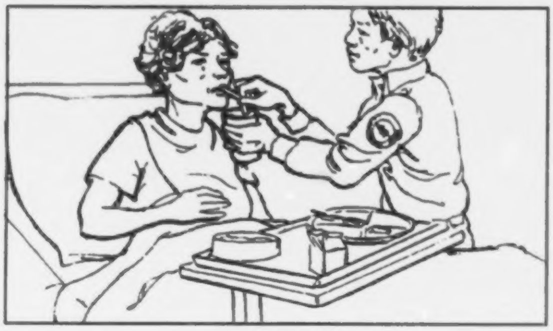
When feeding a patient, the important thing is not to rush that patient. If a patient is very weak, it may take a very long time to chew food so talk to the patient as you feed her. If a patient cannot see, explain what you are going to feed the patient. Pay close attention to be sure the patient does not choke.

Before feeding a patient, she must be prepared for the meal. You must check to see if she needs to go to the bathroom, that her hands are clean, and that there is a pleasant environment in which to eat. The patient will be more inclined to eat if the mealtime is a pleasant experience.

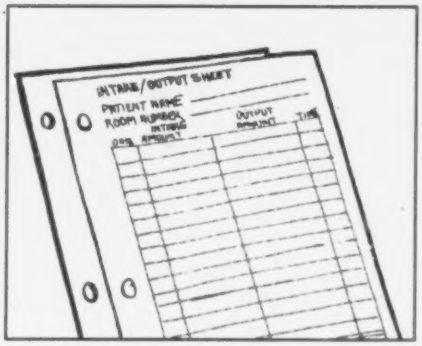


A. Terms

Paralyzed - condition which makes a patient unable to move a part or all of the body

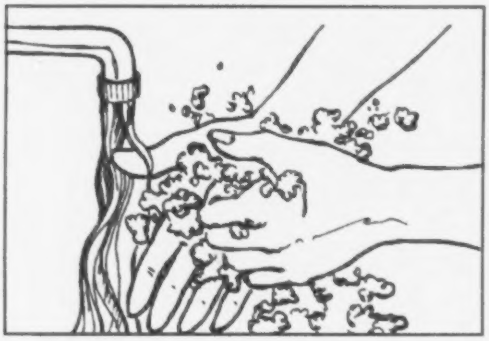


Intake and Output sheet - paper on which all fluid a patient takes in or puts out is recorded

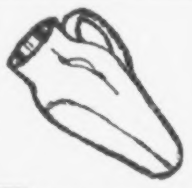

INTAKE/OUTPUT SHEET
PATIENT NAME
ROOM NUMBER
INTAKE
OUTPUT
AMOUNT

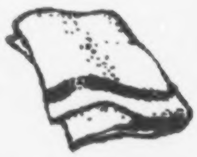
B. Steps of Procedure for Preparing a Patient for a Meal

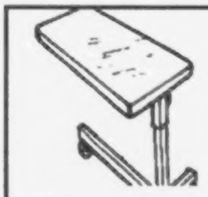
1. Wash hands.



2. Assemble equipment.


☐ Urinal


☐ Washcloth

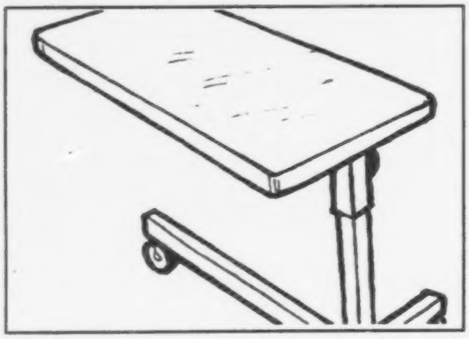

☐ Bed table

3. Identify and greet patient. Identify self.

4. Tell patient you are getting her ready for a meal.

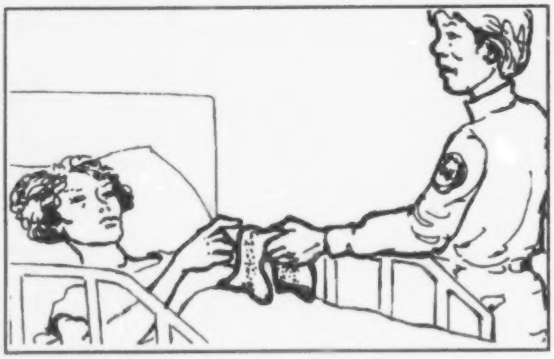
5. Provide before meal care: offer bedpan and/or urinal.

6. Clear overbed table for food tray. Place fresh glass of water within reach.



NOTE: Put away unsightly equipment such as bedpan or urinal. Air room of unpleasant odors.

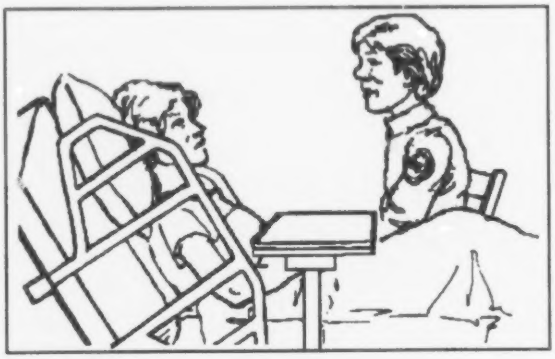
7. Bring patient a damp washcloth to wash hands.



NOTE: If patient is unable to wash hands, you must wash them. Also make sure dentures are clean and in patient's mouth.

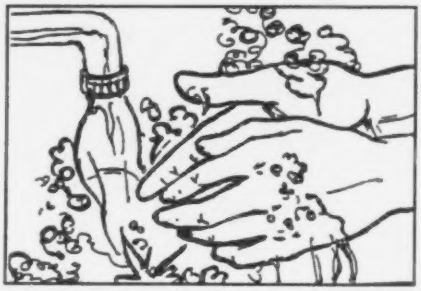
8. Raise head of bed to sitting position, if allowed. Straighten linens.

9. Put overbed table across bed.

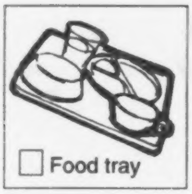


C. Steps of Procedure for Feeding a Patient

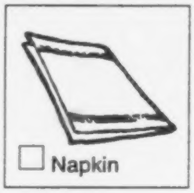
1. Wash your hands.



2. Assemble equipment.

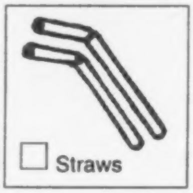


☐ Food tray



☐ Napkin

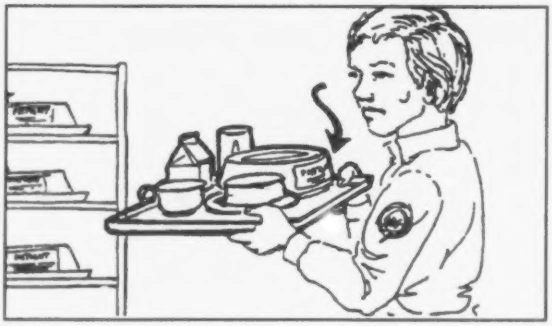
☐ Washcloth



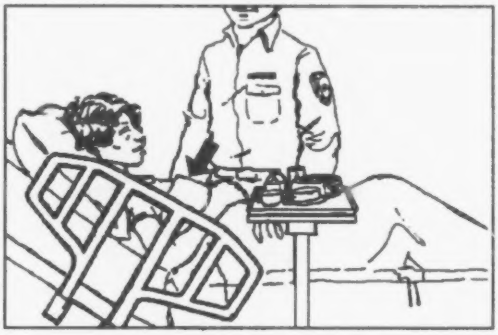
☐ Straws

3. Take patient's tray from food cart, double check patient's name and type of diet on the tray to make sure it is the correct one.

4. Place tray on overbed table and uncover food.

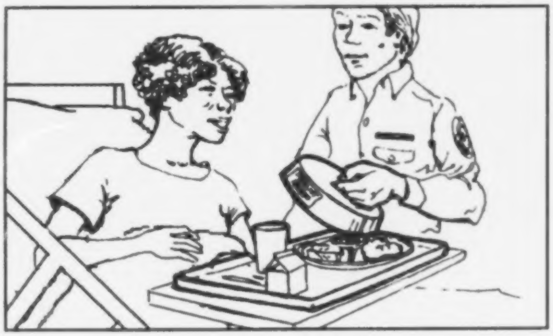


5. Lower side rail on bed.

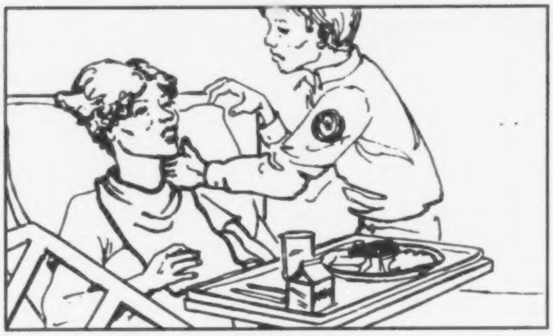


6. Explain that you will help patient to eat.

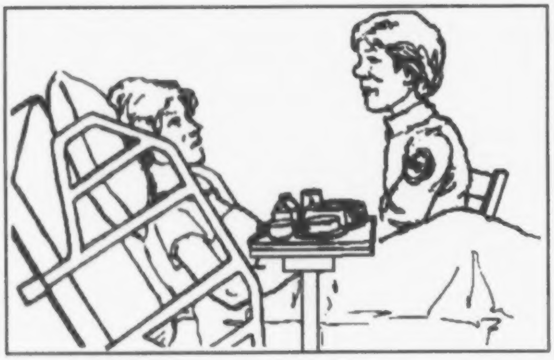
7. Check tray to be sure everything is there.



8. Tuck napkin under patient's chin.



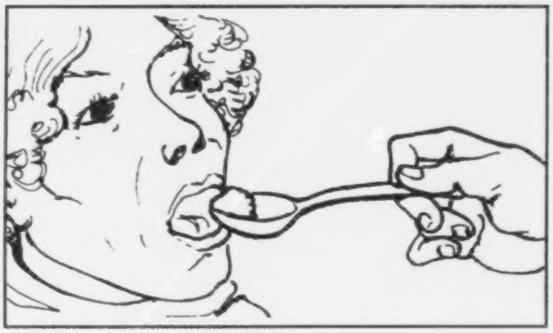
9. Sit down in chair facing patient.



10. Prepare food: cut up meat, butter bread, pour tea or coffee, etc.

NOTE: Add salt, pepper, or sugar to food only if patient is allowed to have them. If allowed, ask if patient desires seasoning.

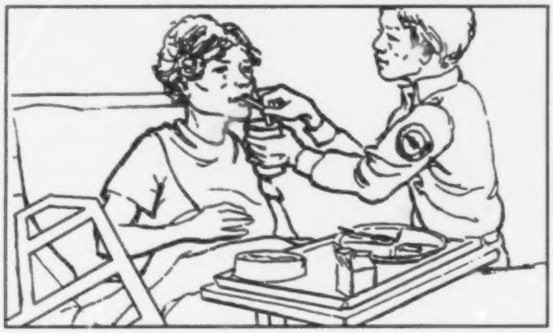
11. Ask patient in what order she wants her food served. Name each mouthful of food as you offer it.



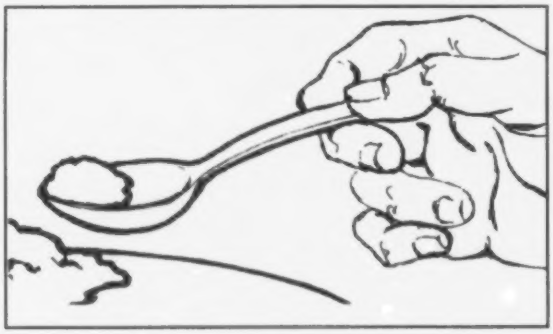
NOTE: Warn patient if food you offer is hot or cold.

12. Let patient help if possible.

13. If patient can't drink from a glass, use a straw for giving liquids. Hold glass in one hand and straw in the other. Use new straw for each liquid.



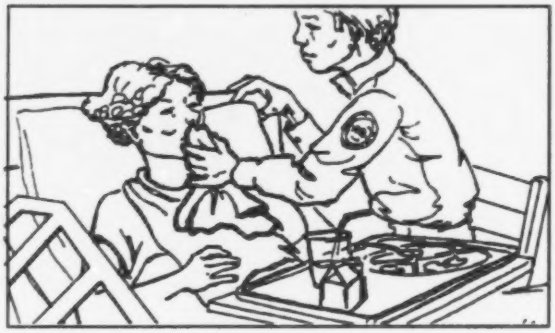
14. Use spoon to give small bites and feed slowly, allowing time for chewing, swallowing, and breathing.



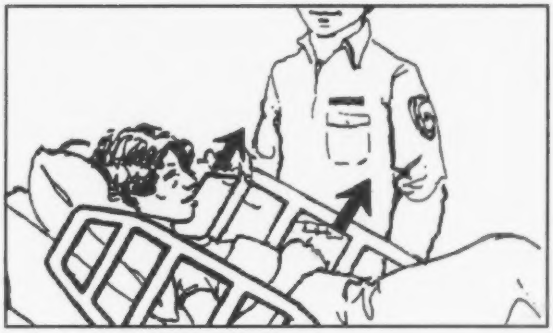
15. Put food in one side of patient's mouth so food can be more easily chewed.

NOTE: If patient is paralyzed on one side, be sure to place food in side of mouth that is not paralyzed.

16. Alternate between liquids and solid foods.
17. Wipe patient's mouth as needed.
18. When patient has finished eating, help to wipe mouth with a napkin, or you do it.

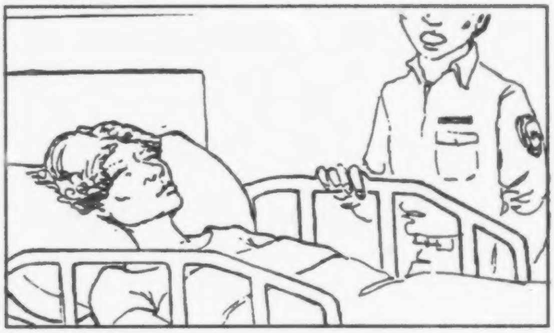


19. Move overbed table away and pull up side rails if appropriate.



20. Wash patient's hands and face.

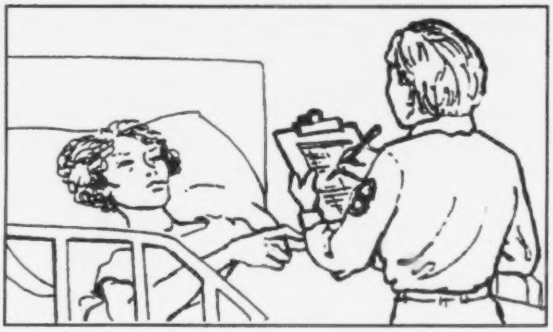
21. Lower head of bed and make patient comfortable.



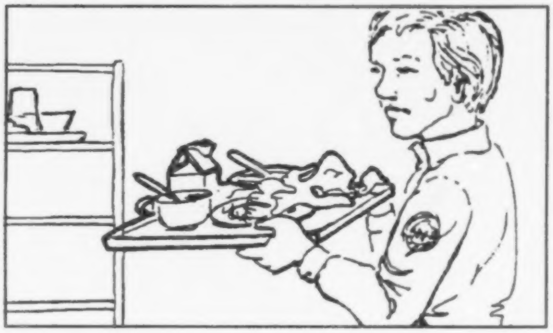
NOTE: Make sure head of bed is not completely lowered so patient does not aspirate if she vomits.

22. Place call light within reach.

23. Record on the appropriate sheet how much of the meal patient has eaten. Record fluid intake on the Intake and Output sheet as directed.



24. Put tray back on cart.



25. Wash your hands. Throw away napkin, or put washcloth with dirty linen.

26. Report anything unusual to charge nurse.

Feeding the Patient
Written Evaluation

Circle the letter that corresponds to the best answer.

1. Before feeding patient, you should:

   a. Encourage patient to eat quickly.
   b. Offer bedpan or urinal.
   c. Sample the food.
   d. Take patient for a walk.

2. The first thing you should do after you remove a tray from the food cart:

   a. Double check patient's name on food tray.
   b. Sample the food from patient's tray.
   c. Wash your hands.
   d. Eat the food you like.

3. When feeding a patient who cannot see, you should:

   a. Sneak bites of food for yourself.
   b. Name food as you feed it to patient.
   c. Have patient guess what the food is.
   d. Not talk, the patient can figure out what food it is when she tastes it.

4. If food is very hot or very cold, you should:

   a. Warn the patient.
   b. Not feed the food to the patient.
   c. Eat the food yourself.
   d. Give it to the patient without warning.

Match terms in Column A with definitions in Column B.

Column A	**Column B**
___5. Paralyzed	a. Condition in which a patient is unaware of things
___6. Intake and Output Sheet	b. Condition which makes a patient unable to move a part or all of the body
	c. Paper on which all fluid a patient takes in or puts out is recorded
	d. Paper on which a patient's feelings are recorded

Feeding the Patient
Evaluation

________________________ has successfully performed the following steps of procedure.
(Student)

Preparing a Patient for a Meal		**Yes**	**No**	**Comments**
1.	Wash hands.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Tell patient you are getting her ready for a meal.			
5.	Provide before meal care: offer bedpan and/or urinal.			
6.	Clear overbed table for food tray. Place fresh glass of water within reach. **NOTE:** Put away unsightly equipment such as bedpan or urinal. Air room of unpleasant odors.			
7.	Bring patient a damp washcloth to wash hands. **NOTE:** If patient is unable to wash hands, you must wash them. Also make sure dentures are clean and in patient's mouth.			
8.	Raise head of bed to sitting position, if allowed. Straighten linens.			
9.	Put overbed table across bed.			
Feeding a Patient				
1.	Wash your hands.			
2.	Assemble equipment.			
3.	Take patient's tray from food cart, double check patient's name and type of diet on the tray to make sure it is the correct one.			
4.	Place tray on overbed table and uncover food.			
5.	Lower side rail on bed.			
6.	Explain that you will help patient to eat.			
7.	Check tray to be sure everything is there.			
8.	Tuck napkin under patient's chin.			
9.	Sit down in chair facing patient.			
10.	Prepare food: cut up meat, butter bread, pour tea or coffee, etc. **NOTE:** Add salt, pepper, or sugar to food only if patient is allowed to have them. If allowed, ask if patient desires seasoning.			
11.	Ask patient in what order she wants her food served. Name each mouthful of food as you offer it. **NOTE:** Warn patient if food you offer is hot or cold.			

Feeding a Patient Cont.		Yes	No	Comments
12.	Let patient help if possible.			
13.	If patient can't drink from a glass, use a straw for giving liquids. Hold glass in one hand and straw in the other. Use new straw for each liquid.			
14.	Use spoon to give small bites and feed slowly, allowing time for chewing, swallowing, and breathing.			
15.	Put food in one side of patient's mouth so food can be more easily chewed. **NOTE:** If patient is paralyzed on one side, be sure to place food in side of mouth that is not paralyzed.			
16.	Alternate between liquids and solid foods.			
17.	Wipe patient's mouth as needed.			
18.	When patient has finished eating, help to wipe mouth with a napkin, or you do it.			
19.	Move overbed table away and pull up side rails if appropriate.			
20.	Wash patient's hands and face.			
21.	Lower head of bed and make patient comfortable. NOTE: Make sure head of bed is not completely lowered so patient does not aspirate if she vomits.			
22.	Place call light within reach.			
23.	Record on the appropriate sheet how much of the meal patient has eaten. Record fluid intake on the Intake and Output sheet as directed.			
24.	Put tray back on cart.			
25.	Wash your hands. Throw away napkin, or put washcloth with dirty linen.			
26.	Report anything unusual to charge nurse.			

Student's Signature/Date

Instructor's Signature/Date

Bathing

Unit Objective

After completing this unit, you should be able to give or assist with a complete bed bath.

Specific Objectives

After completing this unit, you should be able to:

A. Give a complete bed bath according to steps of procedure.

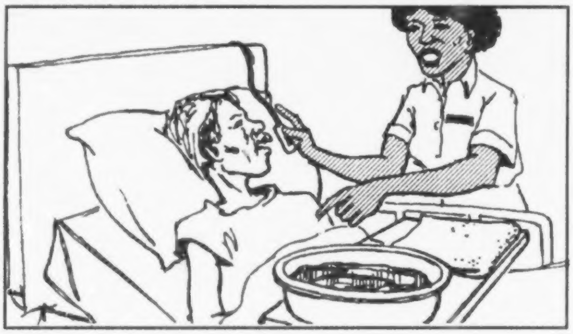
B. Assist a patient with a complete bed bath according to steps of procedure.

Introduction

Patients who are unable to shower or walk to the bathroom must bathe in bed. Some will be able to partially bathe themselves. You will assist these patients in completing them bed bath. Some patients will be able to assist more than others. Some patients will need a complete bed bath is given to them by the caregiver. A complete bath given to a helpless patient in which the caregiver washes all parts of the patient's body.

Patients are encouraged to wash themselves as soon as their condition permits and to do as much as possible for themselves as soon as they are able.

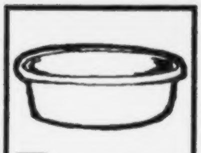
In this unit, you will learn to give a complete bath and assist a patient with a complete bed bath.



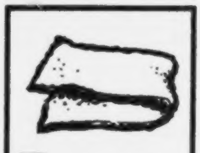
A. Steps of Procedure for Giving a Complete Bed Bath

1. Wash your hands. Put on gloves.

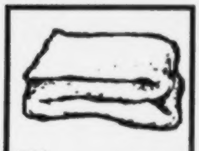
2. Assemble equipment.



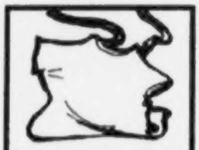
☐ Wash Basin



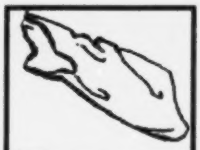
☐ Washcloth



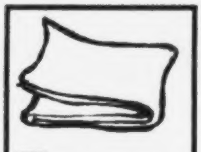
☐ Bath Towel



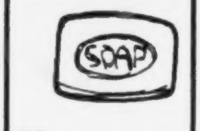
☐ Clean Gown



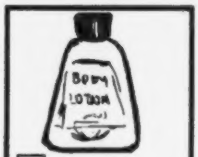
☐ Linen Bag



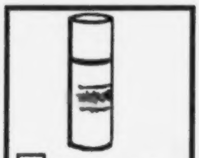
☐ Bath Blanket



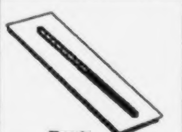
☐ Soap



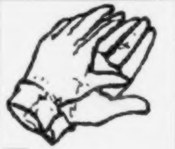
☐ Lotion



☐ Deodorant



☐ Bath Thermometer

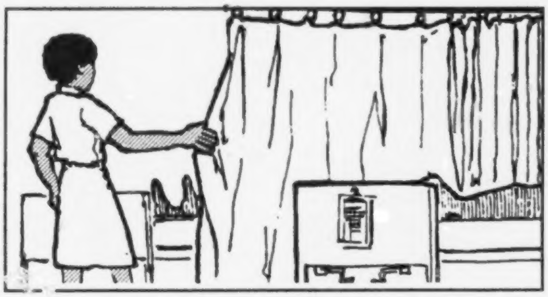


☐ Gloves

3. Identify and greet patient.
   Identify self.

4. Explain what you are going to do.

5. Provide privacy.

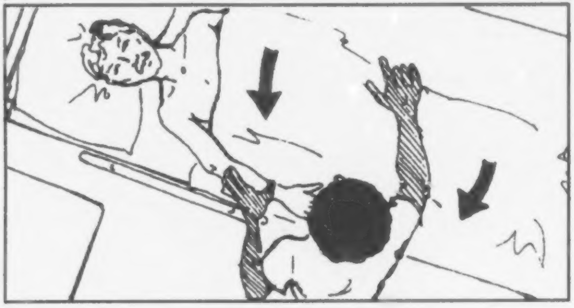


6. Assist with oral hygiene and shaving (if applicable).

7. Offer bedpan/urinal; then empty, clean, and put it away.

8. Remove gloves and dispose in appropriate container. Wash hands. Put on clean gloves.

9. Place patient in supine(back-lying) position near the side of the bed nearest you.



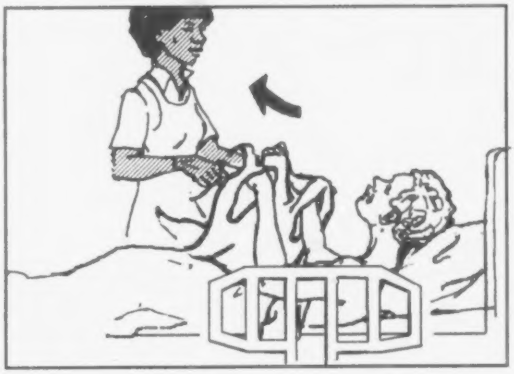
10. Untuck bed linens. Place linen bag on chair.

11. Remove bedspread and blanket. Fold and place on chair if reusing, otherwise place in linen bag.

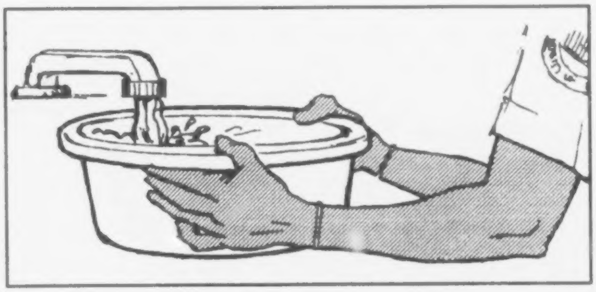
12. Cover top sheet with bath blanket. Ask patient to hold bath blanket in place; if unable, tuck under patient's shoulders.

13. Remove top sheet without removing bath blanket and place in linen bag at bedside.

14. Remove patient's gown or pajamas. Place in linen bag.

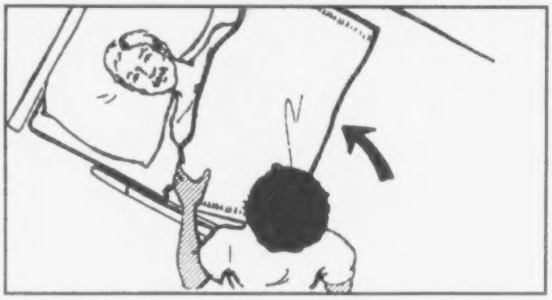


15. Fill bath basin 2/3 full of warm water (115°F). Use bath thermometer to test temperature.

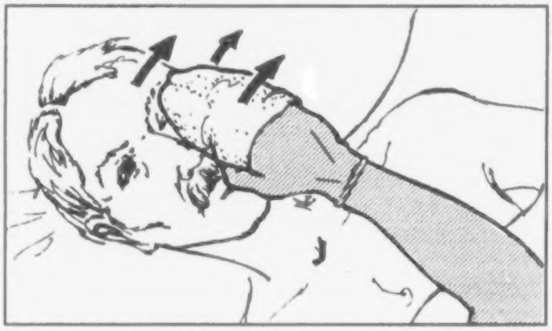


16. Lower side rail. Place bath towel across patient's chest.

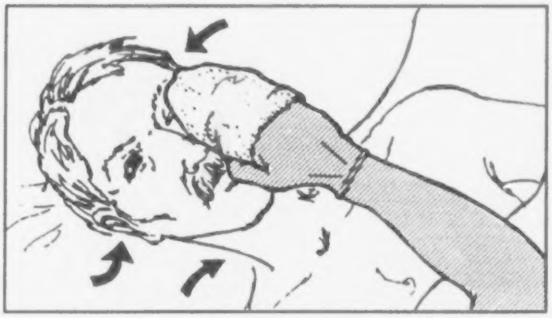
17. Wet washcloth and squeeze out excess water.



18. Wash eyes first. Start at inner corner and work out. Use different area of washcloth for each eye. Don't dangle the ends of washcloth.

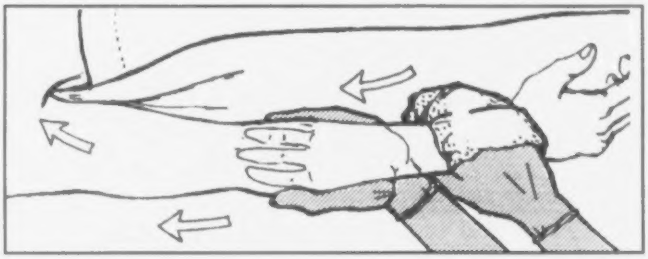


19. Wash, rinse, and dry face, ears, nose and mouth.

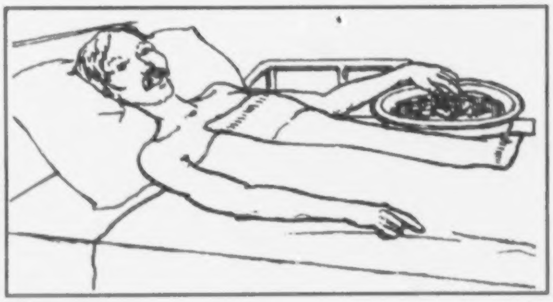


20. Wash, rinse, and dry neck.

21. Expose arm farthest from you. Place bath towel under arm up to axilla (armpit).



22. If patient is able, place basin of water on bed and immerse patient's hand in water and wash.



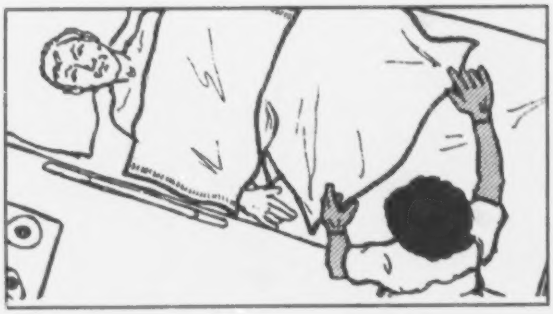
23. Wash and rinse shoulder, axilla, and arm of extremity farthest away.

24. Remove basin and dry arm and shoulder.

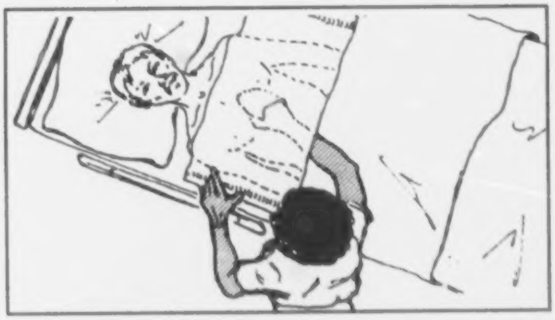
25. Repeat steps 21-24 with arm closest to you.

26. May do fingernail care at this point.

27. Place towel across chest and fold bath blanket to waist.

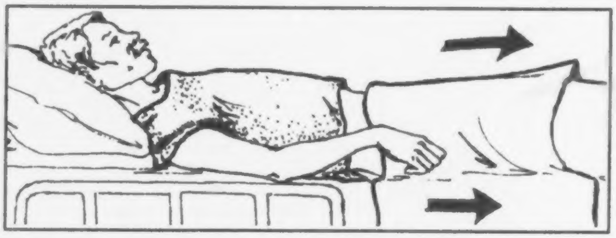


28. Wash and rinse chest and breasts while lifting towel.

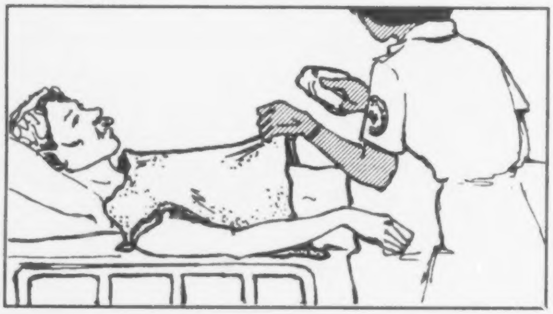


29. Dry skin thoroughly.

30. Fold bath blanket to pubic area. Keep chest covered with towel.

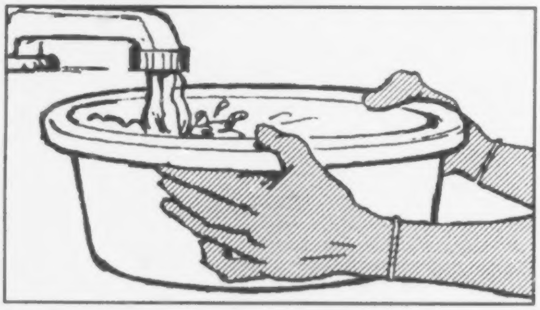


31. Wash, rinse, and dry abdomen. Remove towel and cover with bath blanket.



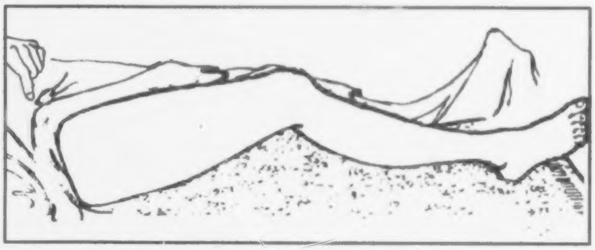
32. Raise side rails if appropriate.

33. Change bath water in basin. Use bath thermometer to test temperature.



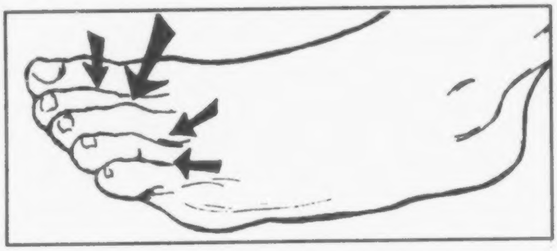
34. Lower side rail.

35. Expose the farthest leg. Flex (bend) leg and place bath towel lengthwise under the leg up to the buttocks.



36. Wash and rinse leg and foot.

37. Dry leg, foot, and in between toes.



38. Repeat steps 35-37 on leg nearest you. Cover patient with bath blanket.

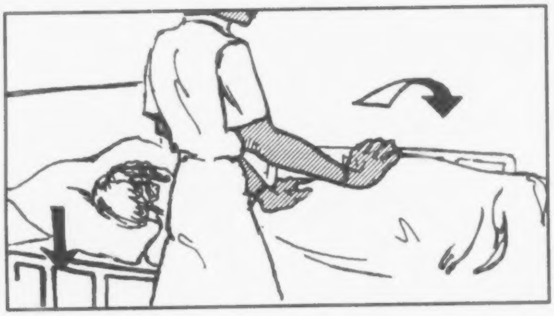
39. May do toenail care at this point.

40. Place towel and washcloth in linen bag and get clean ones.

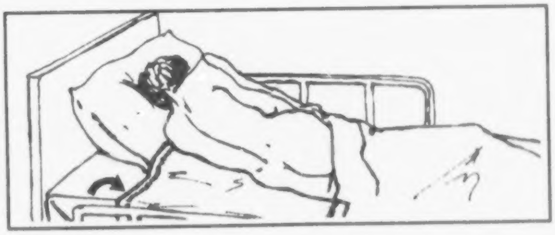
41. Raise side rails.

42. Change bath water in basin. Remember to use bath thermometer to test temperature.

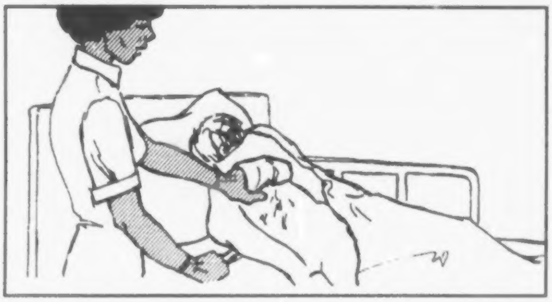
43. Lower side rails. Ask or assist patient to turn on side with back facing you.



44. Fold bath blanket over patient's side to expose back and buttocks; place clean towel parallel to patient's back.

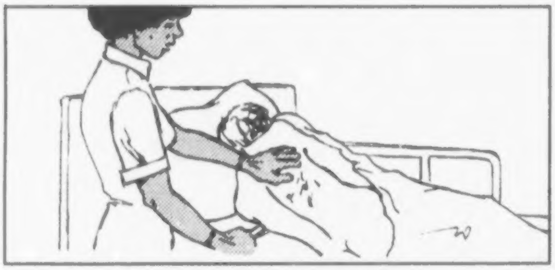


45. Wash, rinse, and dry back and buttocks. Raise side rails if appropriate.



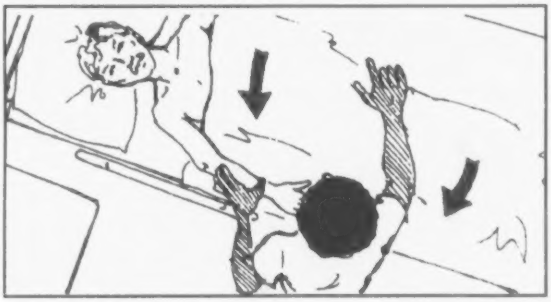
46. Remove gloves and dispose in appropriate container. Wash hands.

47. Lower side rails. Give backrub using warmed lotion paying special attention to bony areas.



48. Put on gloves.

49. Turn patient to back and place clean towel under buttocks.



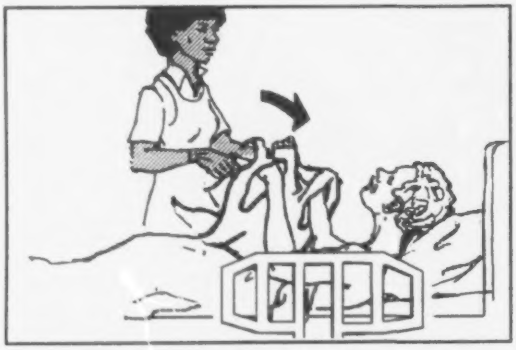
50. Wash peri area from front to back.

51. Place dirty linen in appropriate container.

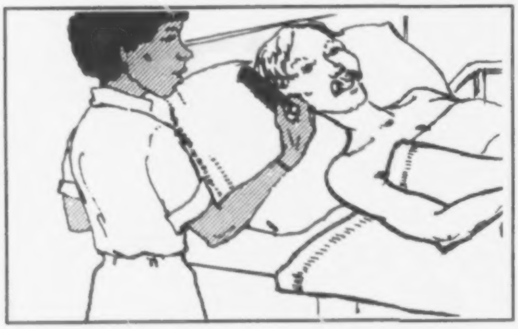
52. Raise side rails if appropriate. Remove gloves and dispose in appropriate container. Wash hands.

53. Apply warmed lotion as needed and deodorant.

54. Lower side rails. Put clean clothing on patient without exposing him.



55. Comb hair, apply cosmetics if applicable.



56. Raise side rails if appropriate. Remove, clean, and store equipment.

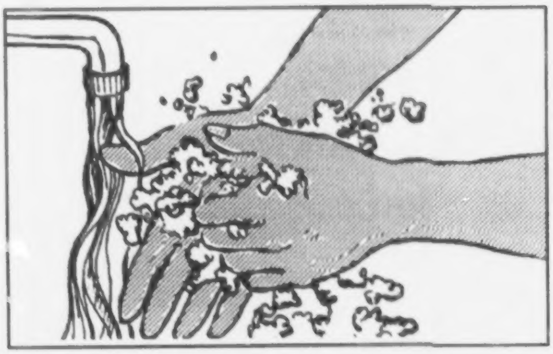
57. Wash your hands.

58. Make the patient comfortable; place call signal within reach.

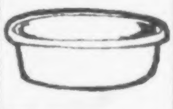
59. Record observations and report anything unusual to charge nurse.

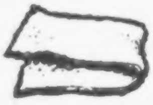
B. Steps of Procedure for Assisting Patient with a Complete Bed Bath

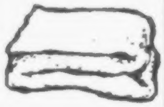
1. Wash hands. Put on gloves.

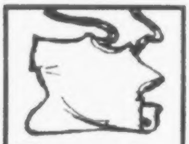


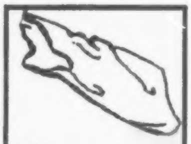
2. Assemble equipment.

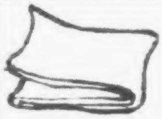

☐ Wash Basin


☐ Washcloth


☐ Bath Towel


☐ Clean Gown

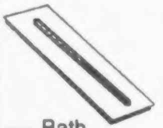

☐ Linen Bag


☐ Bath Blanket

☐ Soap

☐ Lotion

☐ Deodorant


☐ Bath Thermometer

☐ Gloves

3. Identify and greet patient. Identify self.

4. Explain what you are going to do.

5. Place bath blanket and clean gown on chair beside bed.

6. Pull curtain for privacy.

NOTE: Oral hygiene and shaving may be done at this point if necessary or desired.

7. Offer bedpan/urinal. Then empty, clean, and put it away.

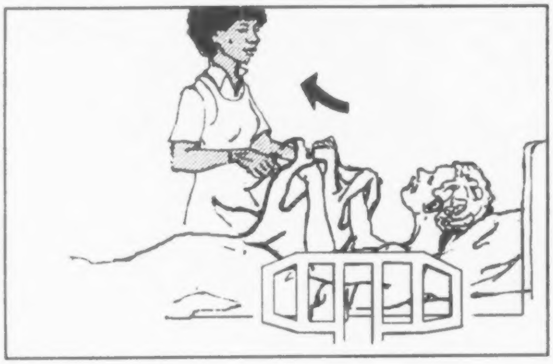
8. Remove and discard gloves in appropriate container. Wash your hands. Put on clean gloves.

9. Place linen bag on chair. Fold bedspread to foot of bed.

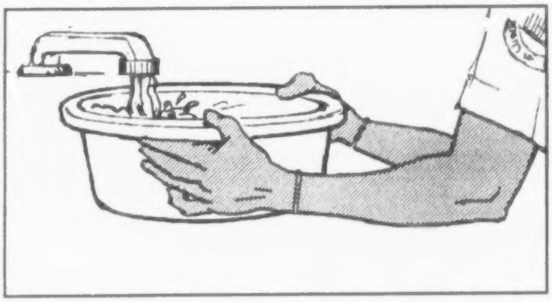
NOTE: If a clean bedspread and blanket will be put on the bed, place used bedspread and blanket in linen bag. If reusing, fold and place on back of chair.

10. Place the bath blanket over the top sheet. Ask patient to hold the blanket in place. Remove the top sheet from underneath without uncovering the patient. Put in laundry bag.

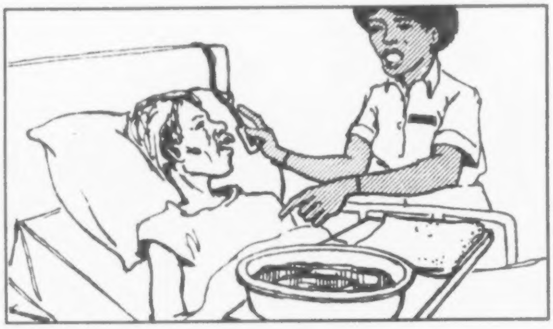
11. Remove patient's gown, keeping patient covered with bath blanket. Put gown in laundry bag.



12. Fill wash basin about two-thirds full with warm water at 115°F. Use bath thermometer to test the temperature.



13. Place wash basin on overbed table. Make sure basin, soap, towel, and washcloth are within patient's reach.



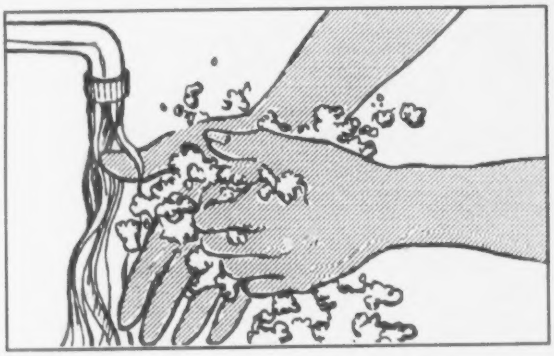
14. Ask patient to wash areas of body that can be easily reached.

15. Place call light next to patient. Ask patient to press light when finished.

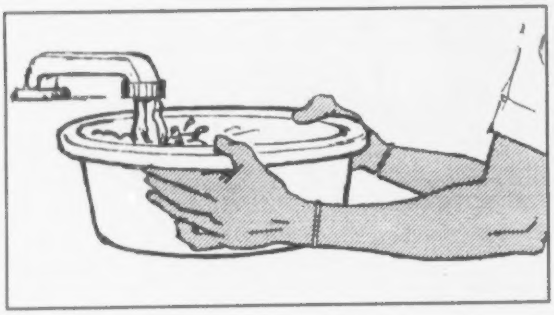
16. Remove gloves and discard in appropriate container. Wash your hands and leave room.

17. Return when patient presses call light.

18. Wash hands. Put on gloves.



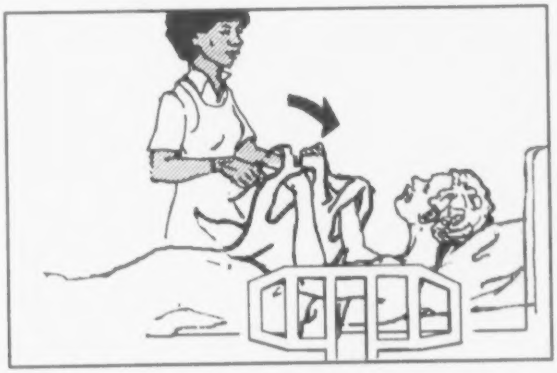
19. Empty the water and refill basin 2/3 full with clean, warm water and place on bedside table. Test temperature of water (115°F) with bath thermometer.



20. Lower side rail. Wash areas of body that patient was unable to reach. Rinse and dry. Rub back and buttocks with lotion.

NOTE: The body parts washed by the patient plus the body parts washed by the caregiver should equal a complete bed bath.

21. Help patient put on gown or pajamas.



22. Pull sheet over patient, remove bath blanket, pull side rail up if appropriate, and open curtain.

NOTE: If the patient is allowed out of bed, assist patient to a chair. Make the bed. Hair care may be done at this time.

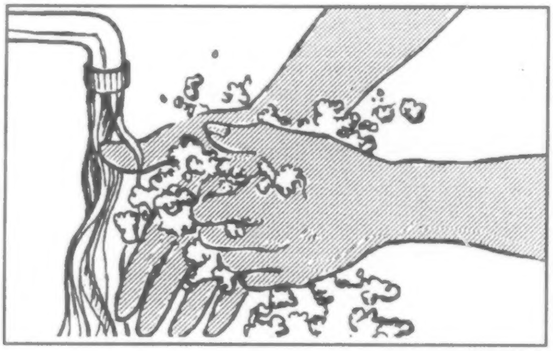
23. Empty wash basin into bathroom sink. Rinse and dry basin.

24. Return basin, soap, and lotion to bedside stand.

25. Put dirty washcloth and towel in laundry bag.

26. Make patient comfortable; place call light within reach.

27. Remove gloves and discard in appropriate container. Wash your hands.



28. Record observations and report anything unusual to the charge nurse.

Bathing

Written Evaluation

Circle the letter that corresponds to the best answer.

1. When bathing a patient, begin by washing:

   a. Patient's face.
   b. Patient's feet.
   c. Patient's bedclothes.
   d. Patient's back.

2. When giving a complete bed bath, the caregiver:

   a. Washes all of the patient.
   b. Washes only part of the patient.
   c. Allows the patient to wash him/herself.
   d. Washes only the areas that are dirty.

3. When assisting a patient with complete bed bath, the caregiver:

   a. Washes only the patient's face.
   b. Washes only areas the patient isn't able to wash.
   c. Washes all of the patient.
   d. Washes the face and peri area only.

Bathing

Evaluation

____________________has successfully performed the following steps of procedure.
(Student)

Giving a Complete Bed Bath		Yes	No	Comments
1.	Wash your hands. Put on gloves.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Provide privacy.			
6.	Assist with oral hygiene and shaving (if applicable).			
7.	Offer bedpan/urinal; then empty, clean, and put it away.			
8.	Remove gloves and dispose in appropriate container. Wash hands. Put on clean gloves.			
9.	Place patient in supine(back-lying) position near the side of the bed nearest you.			
10.	Untuck bed linens. Place linen bag on chair.			
11.	Remove bedspread and blanket. Fold and place on chair if reusing, otherwise place in linen bag.			
12.	Cover top sheet with bath blanket. Ask patient to hold bath blanket in place; if unable, tuck under patient's shoulders.			
13.	Remove top sheet without removing bath blanket and place in linen bag at bedside.			
14.	Remove patient's gown or pajamas. Place in linen bag.			
15.	Fill bath basin 2/3 full of warm water (115°F). Use bath thermometer to test temperature.			
16.	Lower side rail. Place bath towel across patient's chest.			
17.	Wet washcloth and squeeze out excess water.			
18.	Wash eyes first. Start at inner corner and work out. Use different area of washcloth for each eye. Don't dangle the ends of washcloth.			
19.	Wash, rinse, and dry face, ears, nose and mouth.			
20.	Wash, rinse, and dry neck.			
21.	Expose arm farthest from you. Place bath towel under arm up to axilla (armpit).			

Giving a Complete Bed Bath Cont.		**Yes**	**No**	**Comments**
22.	If patient is able, place basin of water on bed and immerse patient's hand in water and wash.			
23.	Wash and rinse shoulder, axilla, and arm of extremity farthest away.			
24.	Remove basin and dry arm and shoulder.			
25.	Repeat steps 21-24 with arm closest to you.			
26.	May do fingernail care at this point.			
27.	Place towel across chest and fold bath blanket to waist.			
28.	Wash and rinse chest and breasts while lifting towel.			
29.	Dry skin thoroughly.			
30.	Fold bath blanket to pubic area. Keep chest covered with towel.			
31.	Wash, rinse, and dry abdomen. Remove towel and cover with bath blanket.			
32.	Raise side rails if appropriate.			
33.	Change bath water in basin. Use bath thermometer to test temperature.			
34.	Lower side rail.			
35.	Expose the farthest leg. Flex (bend) leg and place bath towel lengthwise under the leg up to the buttocks.			
36.	Wash and rinse leg and foot.			
37.	Dry leg, foot, and in between toes.			
38.	Repeat steps 35-37 on leg nearest you. Cover patient with bath blanket.			
39.	May do toenail care at this point.			
40.	Place towel and washcloth in linen bag and get clean ones.			
41.	Raise side rails.			
42.	Change bath water in basin. Remember to use bath thermometer to test temperature.			
43.	Lower side rails. Ask or assist patient to turn on side with back facing you.			
44.	Fold bath blanket over patient's side to expose back and buttocks; place clean towel parallel to patient's back.			
45.	Wash, rinse, and dry back and buttocks. Raise side rails if appropriate.			
46.	Remove gloves and dispose in appropriate container. Wash hands.			
47.	Lower side rails. Give backrub using warmed lotion paying special attention to bony areas.			
48.	Put on gloves.			
49.	Turn patient to back and place clean towel under buttocks.			
50.	Wash peri area from front to back.			

Giving a Complete Bed Bath Cont.		Yes	No	Comments
51.	Place dirty linen in appropriate container.			
52.	Raise side rails if appropriate. Remove gloves and dispose in appropriate container. Wash hands.			
53.	Apply warmed lotion as needed and deodorant.			
54.	Lower side rails. Put clean clothing on patient without exposing him.			
55.	Comb hair, apply cosmetics if applicable.			
56.	Raise side rails if appropriate. Remove, clean, and store equipment.			
57.	Wash your hands.			
58.	Make the patient comfortable; place call signal within reach.			
59.	Record observations and report anything unusual to charge nurse.			
Assisting Patient with a Complete Bed Bath				
1.	Wash hands. Put on gloves.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Place bath blanket and clean gown on chair beside bed.			
6.	Pull curtain for privacy. **NOTE:** Oral hygiene and shaving may be done at this point if necessary or desired.			
7.	Offer bedpan/urinal. Then empty, clean, and put it away.			
8.	Remove and discard gloves in appropriate container. Wash your hands. Put on clean gloves.			
9.	Place linen bag on chair. Fold bedspread to foot of bed. **NOTE:** If a clean bedspread and blanket will be put on the bed, place used bedspread and blanket in linen bag. If reusing, fold and place on back of chair.			
10.	Place the bath blanket over the top sheet. Ask patient to hold the blanket in place. Remove the top sheet from underneath without uncovering the patient. Put in laundry bag.			
11.	Remove patient's gown, keeping patient covered with bath blanket. Put gown in laundry bag.			
12.	Fill wash basin about two-thirds full with warm water at 115°F. Use bath thermometer to test the temperature.			
13.	Place wash basin on overbed table. Make sure basin, soap, towel, and washcloth are within patient's reach.			
14.	Ask patient to wash areas of body that can be easily reached.			
15.	Place call light next to patient. Ask patient to press light when finished.			

Assisting Patient with a Complete Bed Bath Cont.		Yes	No	Comments
16.	Remove gloves and discard in appropriate container. Wash your hands and leave room.			
17.	Return when patient presses call light.			
18.	Wash hands. Put on gloves.			
19.	Empty the water and refill basin 2/3 full with clean, warm water and place on bedside table. Test temperature of water (115°F) with bath thermometer.			
20.	Lower side rail. Wash areas of body that patient was unable to reach. Rinse and dry. Rub back and buttocks with lotion. **NOTE:** The body parts washed by the patient plus the body parts washed by the caregiver should equal a complete bed bath.			
21.	Help patient put on gown or pajamas.			
22.	Pull sheet over patient, remove bath blanket, pull side rail up if appropriate, and open curtain. **NOTE:** If the patient is allowed out of bed, assist patient to a chair. Make the bed. Hair care may be done at this time.			
23.	Empty wash basin into bathroom sink. Rinse and dry basin.			
24.	Return basin, soap, and lotion to bedside stand.			
25.	Put dirty washcloth and towel in laundry bag.			
26.	Make patient comfortable; place call light within reach.			
27.	Remove gloves and discard in appropriate container. Wash your hands.			
28.	Record observations and report anything unusual to the charge nurse.			

Student's Signature/Date

Instructor's Signature/Date

Hair Care

Unit Objective

After completing this unit, you should be able to identify when to give hair care, how to comb/brush hair, and how to shampoo hair in the tub bath/shower bath and in bed.

Specific Objectives

After completing this unit, you should be able to:

A. Identify when hair care should be done.

B. Comb/brush hair according to steps of procedure.

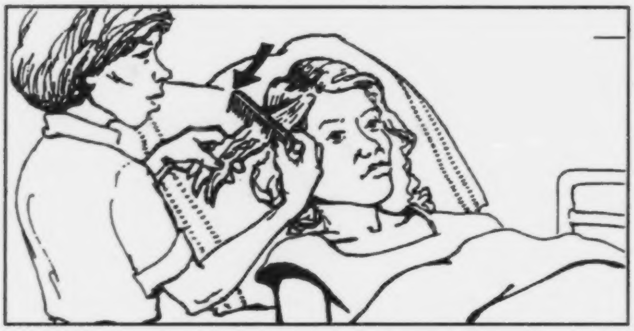
C. Shampoo hair during the tub bath/shower bath according to steps of procedure.

D. Shampoo hair in bed according to steps of procedure.

Introduction

A patient usually feels better when his or her hair has been combed and cared for. As with other types of personal care, a patient may be too weak or sick to properly care for hair. With this in mind, it is important for you to know how and when to care for a patient's hair.

In this unit, you will learn how and when to comb, brush, and shampoo hair.



A. When Hair Care Should Be Done

- Combing/brushing of hair should be done in the morning and during the day as needed. A patient's hair can also be combed/brushed after a bath and before his/her bed is made.

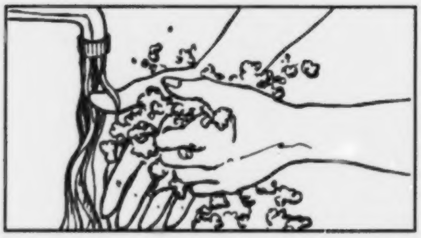
- Hair should be washed at least weekly for most patients and more often if indicated. Washing African-American patients' hair too often will dry it out and possibly cause breakage of the hair.

- Do not shampoo hair as part of the tub bath/shower bath if the patient has a regularly scheduled beauty shop appointment.

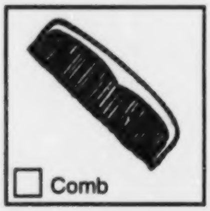
- Some patients may have their hair washed daily if desired.

B. Steps of Procedure for Combing/Brushing Hair

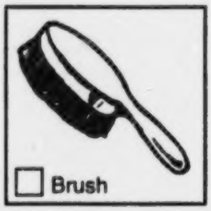
1. Wash your hands.



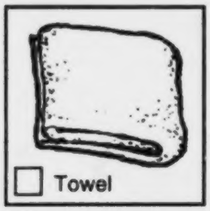
2. Assemble equipment.



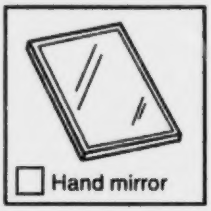
☐ Comb



☐ Brush



☐ Towel



☐ Hand mirror

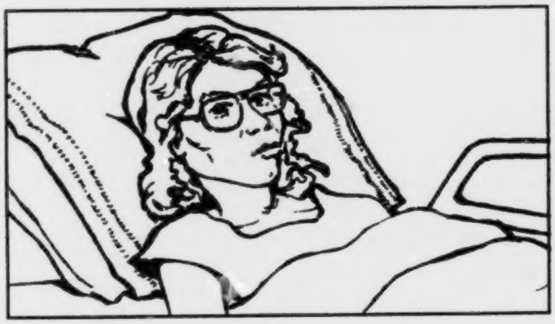
3. Identify and greet patient. Identify self.

4. Explain what you are going to do.

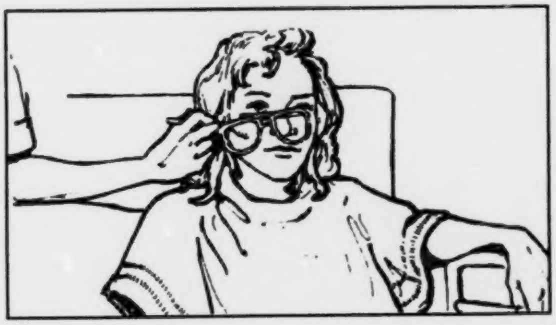
5. Provide privacy. Pull curtain around bed.

6. Lower side rail on side you will work.

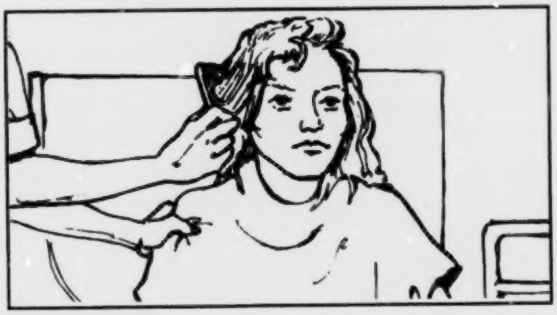
7. Lay towel across pillow and under patient's head. If patient can sit, drape towel across patient's shoulders.



8. If patient is wearing glasses, remove them before you begin. Put glasses in a safe place. Remove hairpins, combs, etc.



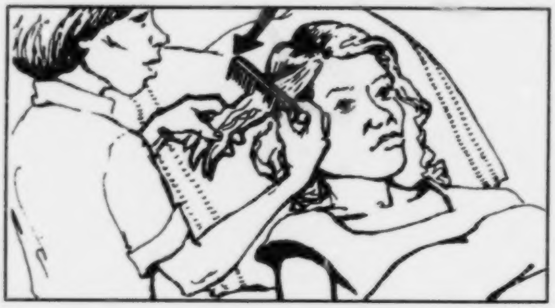
9. Part hair down the middle to make it easier to comb.



10. Brush or comb hair gently, using downward strokes.

NOTE: Ask patient to turn head from side to side or turn it yourself so that you can reach all of the hair. If patient has long hair, ask about braiding it to keep it from getting tangled.

11. For the patient who cannot sit up, separate hair into small sections.

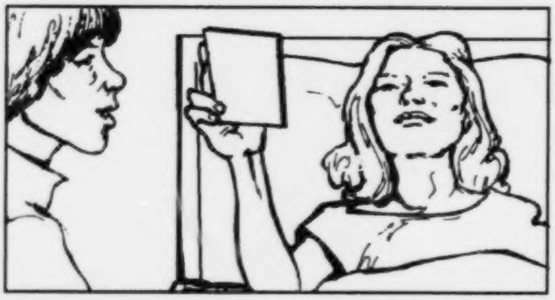


12. Comb each section separately using a downward motion.

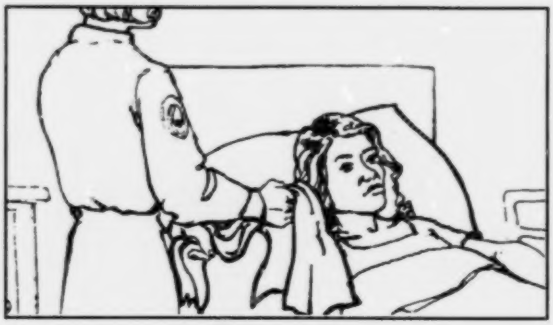
NOTE: Be sure you brush or comb hair on back of head.

13. Style patient's hair in the manner that the patient requests.

14. Let patient use hand mirror, if available.



15. Remove towel when you are finished. Put it with dirty linen.



16. Make patient comfortable. Place call light within reach.

17. Pull up side rails if appropriate.

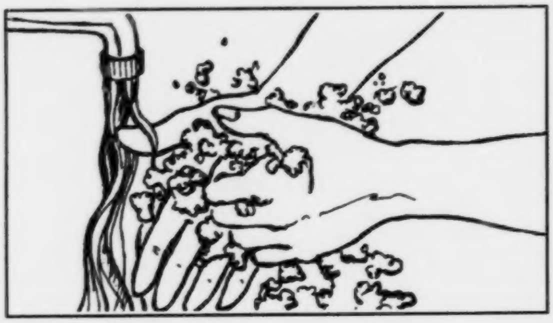
18. Put away comb and brush.

19. Wash your hands.

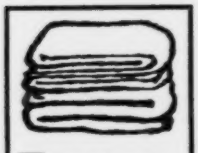
20. Report anything unusual to your supervisor.

C. Steps of Procedure Shampooing During Tub Bath/Shower Bath

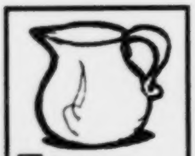
1. Wash your hands.

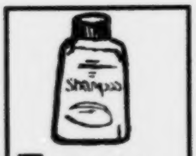


2. Assemble equipment.

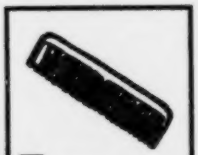

☐ Bath towels

☐ Brush

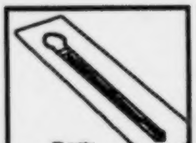

☐ Pitcher


☐ Shampoo

☐ Bath blanket


☐ Comb

☐ Mirror


☐ Bath Thermometer

☐ Conditioner Creme Rinse

☐ Blowdryer

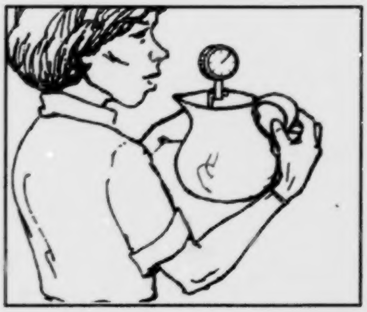
☐ Washcloth

3. Identify and greet patient. Identify self.

4. Explain what you are going to do.

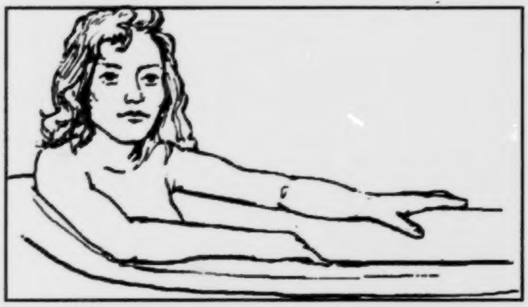
5. Pull curtain to provide for privacy in shower room.

6. Adjust water temperature to 105°-110°F. Use bath thermometer to test temperature.

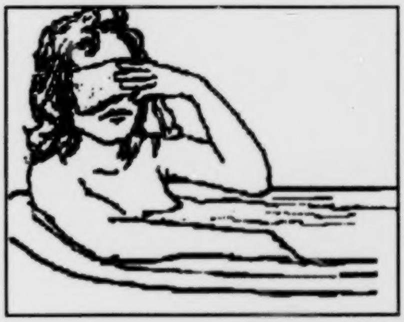


NOTE: Have patient test water.

7. Position patient appropriately in tub or shower.



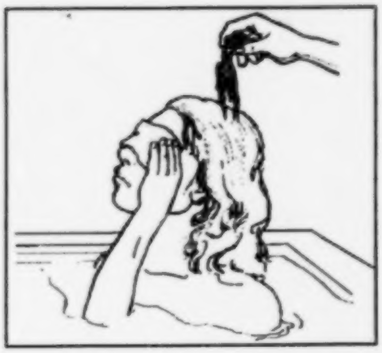
8. Ask patient to hold folded washcloth/ face towel over eyes.



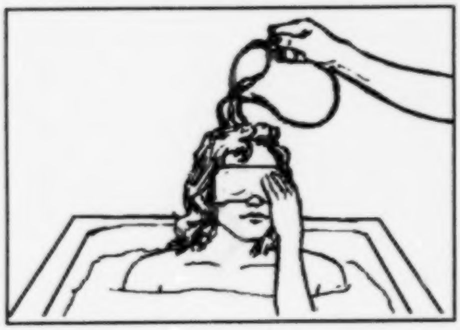
9. Apply water to hair until it is completely wet using nozzle or pitcher.

NOTE: Keep one finger in stream of water to assure correct temperature of water.

10. Apply a capful of shampoo. Work up a good lather, massaging with fingertips.



11. Rinse thoroughly working from front to back.

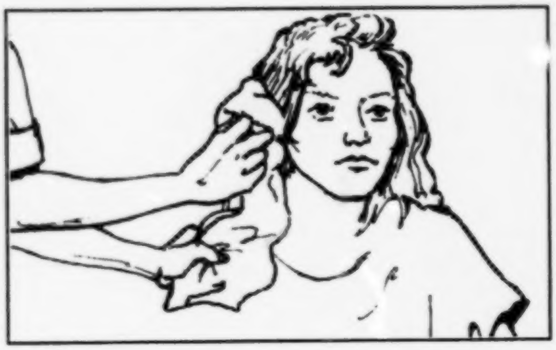


NOTE: Rinsing all soap from scalp prevents irritation and dryness.

12. Repeat sudsing and rinsing, if necessary.

13. Apply conditioner or creme rinse as directed. Rinse thoroughly.

14. If necessary, use a second towel to dry hair.

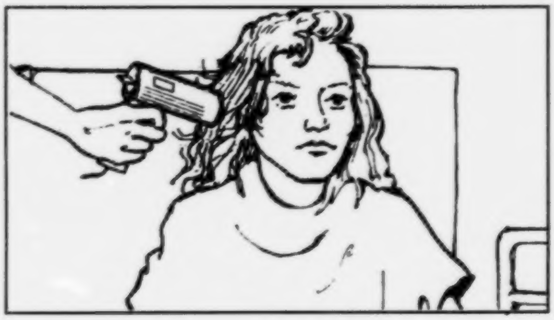


15. Encourage patient to comb own hair to remove snarls and tangles, if able.

NOTE: The hair of African-Americans tends to be extremely dry. Gently comb hair with a wide tooth comb and apply light oil after washing and before combing hair.

16. Apply rollers or set hair if this is to be done.

17. Dry hair quickly. If a hair dryer is available, use it.

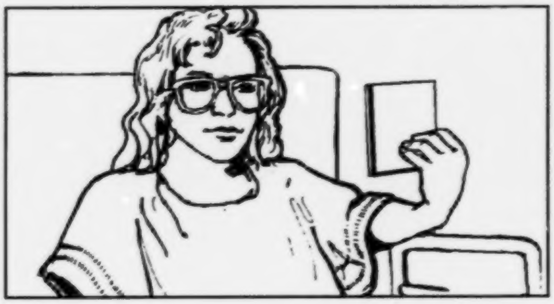


CAUTION: Do not use hair dryer near tub or shower since the dryer may come in contact with water and cause electrocution.

NOTE: If using hand-held dryer, keep your hand under air stream to assure correct temperature. The hair dryer should be on low setting.

18. When hair is dry, remove curlers if used. Comb or brush hair and arrange attractively.

19. Let patient use the hand mirror, if available.



20. Make patient comfortable. Place call light within reach. Pull up side rails if appropriate.

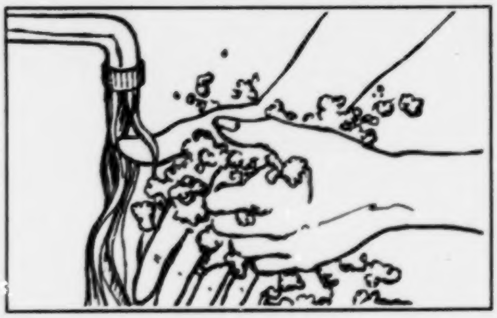
21. Replace shampoo, hair conditioner, bath thermometer, hair dryer, mirror and shower nozzle or pitcher.

22. Clean comb/brush and put away.

23. Put towels with dirty linen.

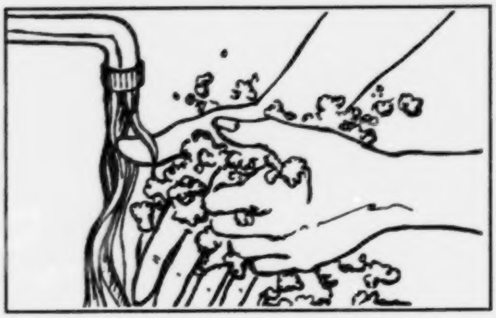
24. Wash hands.

25. Report anything unusual to charge nurse.

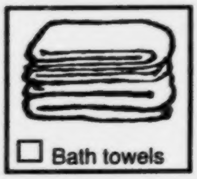


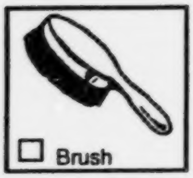
D. Steps of Procedure for Shampooing Hair in Bed

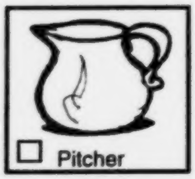
1. Wash your hands.

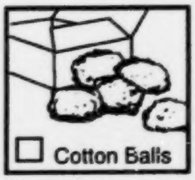


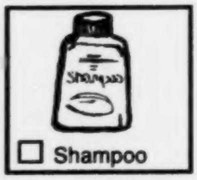
2. Assemble equipment.

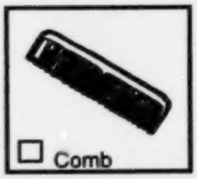

☐ Bath towels

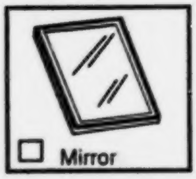

☐ Brush

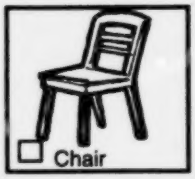

☐ Pitcher

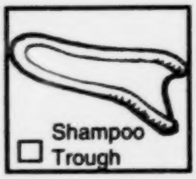

☐ Cotton Balls

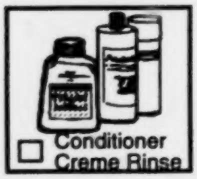

☐ Shampoo

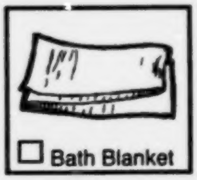

☐ Comb

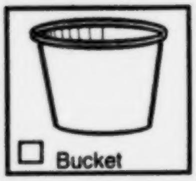

☐ Mirror

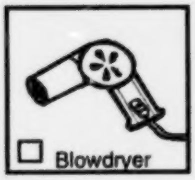

☐ Chair

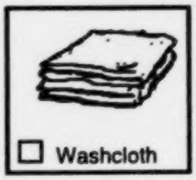

☐ Shampoo Trough

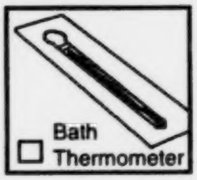

☐ Conditioner Creme Rinse


☐ Bath Blanket


☐ Bucket


☐ Blowdryer

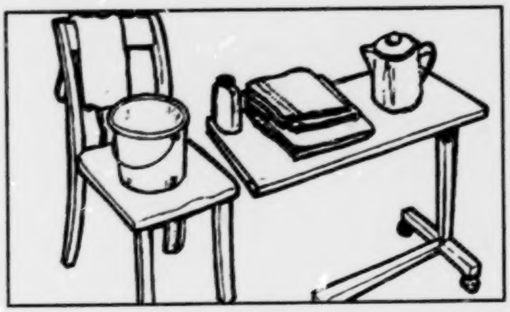

☐ Washcloth


☐ Bath Thermometer

3. Identify and greet patient. Identify self.

4. Explain what you are going to do.

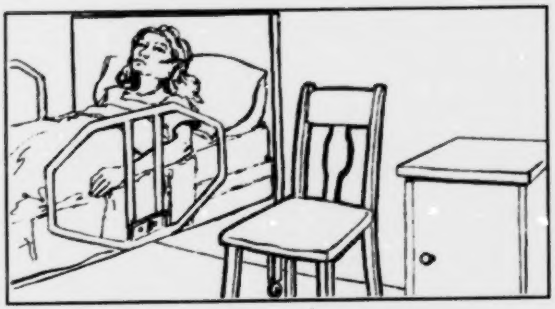
5. Bring all of the above equipment to bedside.



6. Provide privacy. Pull curtain around bed.

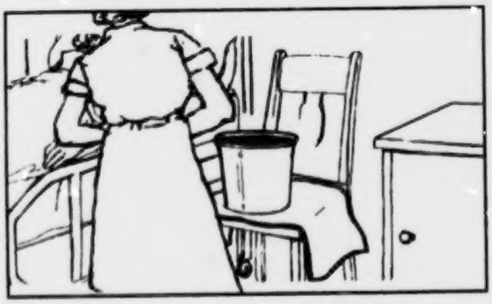
7. If allowed, put head of bed in flat position. Raise bed to highest horizontal position.

8. Put chair at side of bed near patient's head. Chair should be lower than the bed.

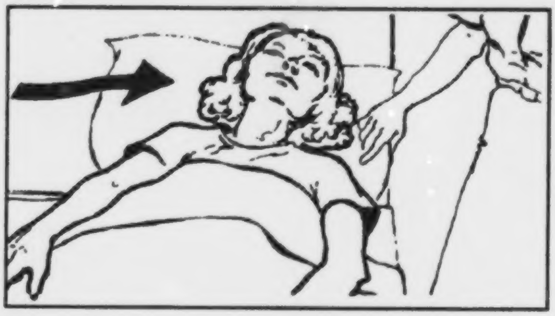


9. Lower side rail on side you will work.

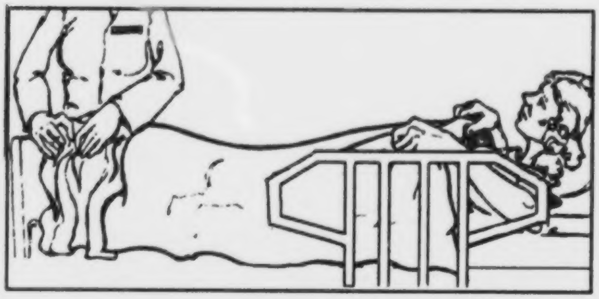
10. Place towel on chair, then set bucket on chair.



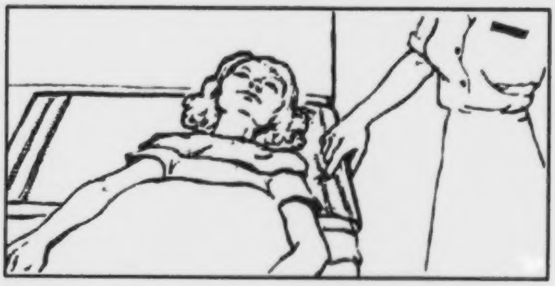
11. Have patient move across bed so that patient's head is close to where you are standing.



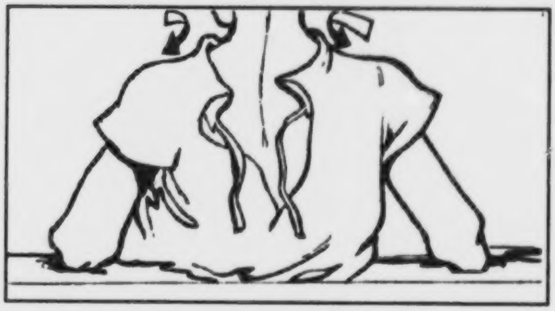
12. Place bath blanket over patient and remove covers from underneath, pulling covers to bottom of bed.



13. Take pillow from under patient's head. Replace with disposable waterproof bed protector.

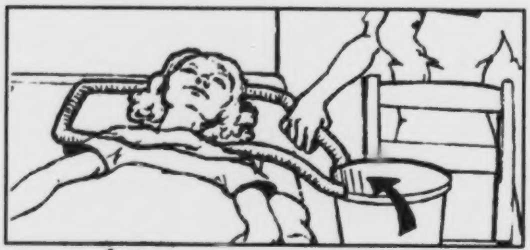


14. Loosen patient's gown at neck and turn neckband under.



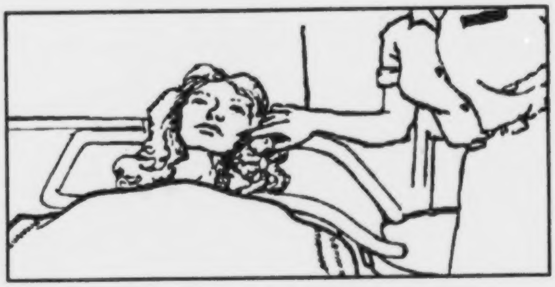
15. Place a towel under patient's head and one around shoulders.

16. Place shampoo trough or arrange plastic sheet under patient's head and on towel.



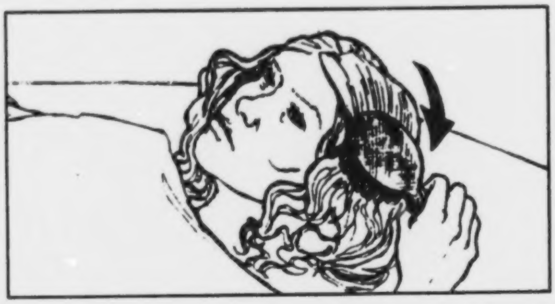
NOTE: Open end of trough or sheet should be hanging over side of bed to form a drain into bucket.

17. Put a cotton ball in each ear of patient and place a towel over patient's chest.

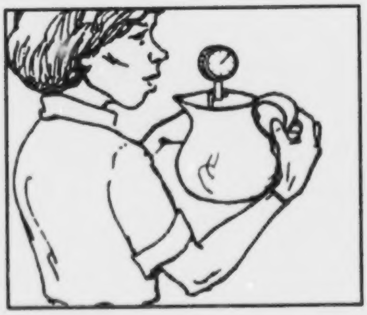


NOTE: Cotton balls help keep the water out of patient's ears.

18. Brush patient's hair. Have patient turn head from side to side so that you can brush each side.

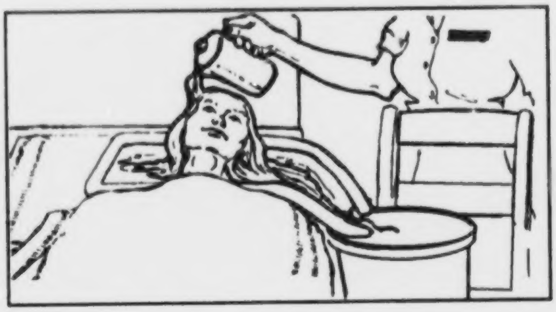


19. Fill pitcher with water. Adjust water temperature to 105°-110°F. Use bath thermometer to test temperature.

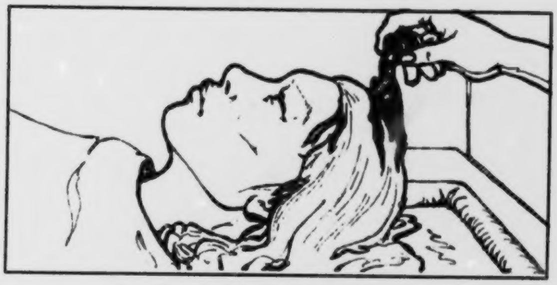


NOTE: Have patient test water.

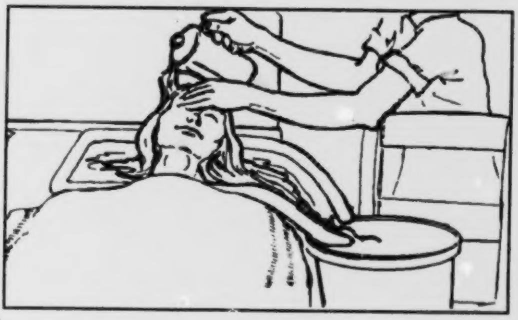
20. Pour water over hair until it is completely wet.



21. Put a capful of shampoo on patient's hair. Wash and massage patient's scalp with your fingertips.



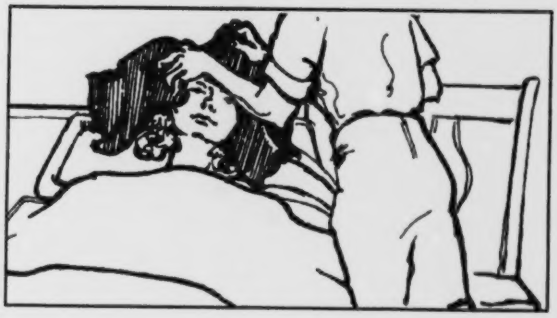
22. Rinse shampoo by pouring another pitcher of water over hair working from front to back. Remember to check water temperature.



NOTE: Use as much water as necessary to rinse all shampoo from hair. Have patient turn head from side to side. Repeat sudsing and rinsing until hair is clean.

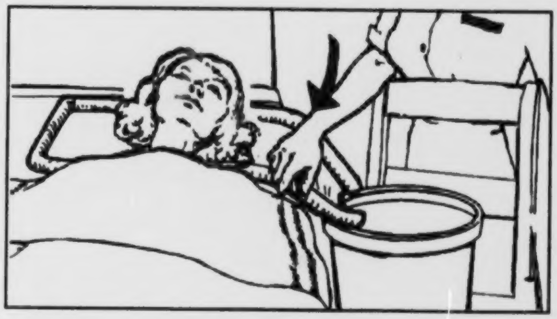
23. Apply conditioner or creme rinse as patient desires. Rinse hair thoroughly.

24. Squeeze excess water from hair. Apply towel to hair.



25. Gently rub patient's hair with towel to dry it as much as possible.

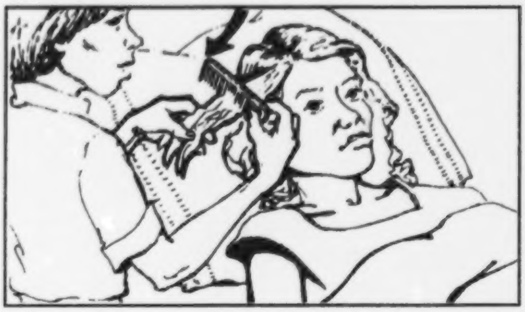
26. Remove shampoo trough from bed and place inside bucket.



27. Remove cotton balls from ears.

28. Change patient's gown if necessary.

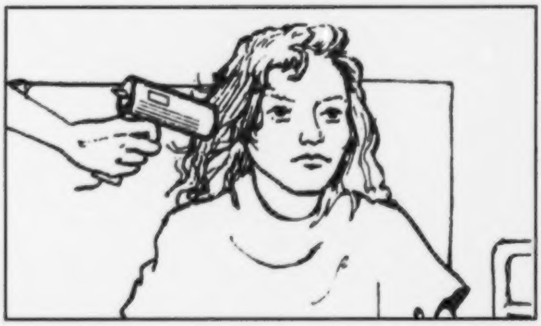
29. Comb patient's hair or encourage patient to comb own hair, if able.



NOTE: For African-American patients, a wide tooth comb is best. Apply a hair dressing. Hair may be braided while wet but if left loose it must be combed constantly to prevent tangles.

30. Apply rollers or set hair if this is to be done.

31. Dry hair quickly. If a hair dryer is available use it.



CAUTION: If using hand-held dryer, keep your hand under air stream so temperature can be felt. Keep on low setting.

32. When hair is dry, remove curlers if used. Comb or brush hair and arrange attractively.

33. Let patient use mirror, if available.

34. Remove bath blanket and at same time pull up covers.

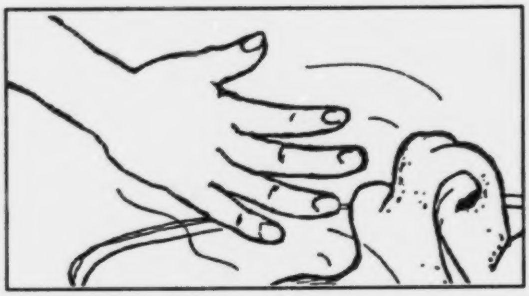
35. Make patient comfortable. Place call light within reach.

36. Pull up side rails if appropriate.

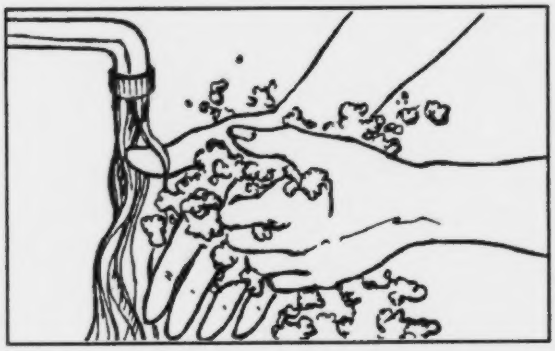
37. Empty water from shampoo trough, pitcher, and bucket. Dry each one and return to its proper place.

38. Put away comb, brush, shampoo, and chair.

39. Place dirty towels, gown, and bath blanket in proper places.



40. Wash your hands.



41. Report anything unusual to your supervisor, including anything unusual about patient's scalp such as sores, swollen areas, redness or dandruff.

Hair Care

Written Evaluation

Circle the letter that corresponds to the best answer.

1. If a patient wears glasses, before giving hair care you should:

   a. Hide the patient's glasses.
   b. Leave the patient's glasses in place.
   c. Remove the patient's glasses.
   d. Wash the patient's glasses.

2. To make a patient's hair easier to comb, you should:

   a. Part hair down the middle.
   b. Cut the patient's hair.
   c. Wet the patient's hair.
   d. Tangle the patient's hair.

3. Before shampooing a patient's hair, you should:

   a. Wet the patient's hair.
   b. Blow dry the patient's hair.
   c. Give the patient a drink of water.
   d. Have a rest break.

4. Before water is applied to the hair, you should:

   a. Wet the patient's hands.
   b. Put the hair in sections.
   c. Ask the patient to cover his/her eyes with a washcloth.
   d. Wash patient's face.

5. When should hair care be done?

   a. Combing and brushing should be done in the morning and during the day as needed.
   b. Hair should be washed at least weekly for all patients and more often if indicated.
   c. Hair should not be shampooed during the shower if patient has a regularly scheduled beauty salon appointment.
   d. All of the above.

Hair Care
Evaluation

______________________ has successful performed the following steps of procedure.
(Student)

Combing/Brushing Hair		Yes	No	Comments
1.	Wash your hands.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Provide privacy. Pull curtain around bed.			
6.	Lower side rail on side you will work.			
7.	Lay towel across pillow and under patient's head. If patient can sit, drape towel across patient's shoulders.			
8.	If patient is wearing glasses, remove them before you begin. Put glasses in a safe place. Remove hairpins, combs, etc.			
9.	Part hair down the middle to make it easier to comb.			
10.	Brush or comb hair gently, using downward strokes. **NOTE**: Ask patient to turn head from side to side or turn it yourself so that you can reach all of the hair. If patient has long hair, ask about braiding it to keep it from getting tangled.			
11.	For the patient who cannot sit up, separate hair into small sections.			
12.	Comb each section separately using a downward motion. **NOTE**: Be sure you brush or comb hair on back of head.			
13.	Style patient's hair in the manner that the patient requests.			
14.	Let patient use hand mirror, if available.			
15.	Remove towel when you are finished. Put it with dirty linen.			
16.	Make patient comfortable. Place call light within reach.			
17.	Pull up side rails if appropriate.			
18.	Put away comb and brush.			
19.	Wash your hands.			
20.	Report anything unusual to your supervisor.			

Shampooing During Tub Bath/Shower Bath		Yes	No	Comments
1.	Wash your hands.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Pull curtain to provide for privacy in shower room.			
6.	Adjust water temperature to 105°-110°F. Use bath thermometer to test temperature. **NOTE:** Have patient test water.			
7.	Position patient appropriately in tub or shower.			
8.	Ask patient to hold folded washcloth/face towel over eyes.			
9.	Apply water to hair until it is completely wet using nozzle or pitcher. **NOTE:** Keep one finger in stream of water to assure correct temperature of water.			
10.	Apply a capful of shampoo. Work up a good lather, massaging with fingertips.			
11.	Rinse thoroughly working from front to back. **NOTE:** Rinsing all soap from scalp prevents irritation and dryness.			
12.	Repeat sudsing and rinsing, if necessary.			
13.	Apply conditioner or creme rinse as directed. Rinse thoroughly.			
14.	If necessary, use a second towel to dry hair.			
15.	Encourage patient to comb own hair to remove snarls and tangles, if able. **NOTE:** The hair of African-Americans tends to be extremely dry. Gently comb hair with a wide tooth comb and apply light oil after washing and before combing hair.			
16.	Apply rollers or set hair if this is to be done.			
17.	Dry hair quickly. If a hair dryer is available, use it. **CAUTION:** Do not use hair dryer near tub or shower since the dryer may come in contact with water and cause electrocution. **NOTE:** If using hand-held dryer, keep your hand under air stream to assure correct temperature. The hair dryer should be on low setting.			
18.	When hair is dry, remove curlers if used. Comb or brush hair and arrange attractively.			
19.	Let patient use the hand mirror, if available.			
20.	Make patient comfortable. Place call light within reach. Pull up side rails if appropriate.			
21.	Replace shampoo, hair conditioner, bath thermometer, hair dryer, mirror and shower nozzle or pitcher.			
22.	Clean comb/brush and put away.			
23.	Put towels with dirty linen.			

Shampooing During Tub Bath/Shower Bath Cont.		**Yes**	**No**	**Comments**
24.	Wash hands.			
25.	Report anything unusual to charge nurse.			
Shampooing Hair In Bed				
1.	Wash your hands.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Bring all of the above equipment to bedside.			
6.	Provide privacy. Pull curtain around bed.			
7.	If allowed, put head of bed in flat position. Raise bed to highest horizontal position.			
8.	Put chair at side of bed near patient's head. Chair should be lower than the bed.			
9.	Lower side rail on side you will work.			
10.	Place towel on chair, then set bucket on chair.			
11.	Have patient move across bed so that patient's head is close to where you are standing.			
12.	Place bath blanket over patient and remove covers from underneath, pulling covers to bottom of bed.			
13.	Take pillow from under patient's head. Replace with disposable waterproof bed protector.			
14.	Loosen patient's gown at neck and turn neckband under.			
15.	Place a towel under patient's head and one around shoulders.			
16.	Place shampoo trough or arrange plastic sheet under patient's head and on towel. **NOTE**: Open end of trough or sheet should be hanging over side of bed to form a drain into bucket.			
17.	Put a cotton ball in each ear of patient and place a towel over patient's chest. **NOTE:** Cotton balls help keep the water out of patient's ears.			
18.	Brush patient's hair. Have patient turn head from side to side so that you can brush each side.			
19.	Fill pitcher with water. Adjust water temperature to 105°-110°F. Use bath thermometer to test temperature. NOTE: Have patient test water.			
20.	Pour water over hair until it is completely wet.			
21.	Put a capful of shampoo on patient's hair. Wash and massage patient's scalp with your fingertips.			

Shampooing Hair in Bed Cont.		Yes	No	Comments
22.	Rinse shampoo by pouring another pitcher of water over hair working from front to back. Remember to check water temperature. NOTE: Use as much water as necessary to rinse all shampoo from hair. Have patient turn head from side to side. Repeat sudsing and rinsing until hair is clean.			
23.	Apply conditioner or creme rinse as patient desires. Rinse hair thoroughly.			
24.	Squeeze excess water from hair. Apply towel to hair.			
25.	Gently rub patient's hair with towel to dry it as much as possible.			
26.	Remove shampoo trough from bed and place inside bucket.			
27.	Remove cotton balls from ears.			
28.	Change patient's gown if necessary.			
29.	Comb patient's hair or encourage patient to comb own hair, if able. **NOTE**: For African-American patients, a wide tooth comb is best. Apply a hair dressing. Hair may be braided while wet but if left loose it must be combed constantly to prevent tangles.			
30.	Apply rollers or set hair if this is to be done.			
31.	Dry hair quickly. If a hair dryer is available use it. **CAUTION**: If using hand-held dryer, keep your hand under air stream so temperature can be felt. Keep on low setting.			
32.	When hair is dry, remove curlers if used. Comb or brush hair and arrange attractively.			
33.	Let patient use mirror, if available.			
34.	Remove bath blanket and at same time pull up covers.			
35.	Make patient comfortable. Place call light within reach.			
36.	Pull up side rails if appropriate.			
37.	Empty water from shampoo trough, pitcher, and bucket. Dry each one and return to its proper place.			
38.	Put away comb, brush, shampoo, and chair.			
39.	Place dirty towels, gown, and bath blanket in proper places.			
40.	Wash your hands.			
41.	Report anything unusual to your supervisor, including anything unusual about patient's scalp such as sores, swollen areas, redness or dandruff.			

Student's Signature/Date

Instructor's Signature/Date

Mouth Care

Unit Objective

After completing this unit, you should be able to give mouth care to conscious and unconscious patients, and clean dentures.

Specific Objectives

After completing this unit, you should be able to:

A. Match terms in this unit with their correct definitions.

B. Give mouth care to a conscious patient who can assist with care according to steps of procedure.

C. Give mouth care to a conscious patient who cannot assist with care according to steps of procedure.

D. Give mouth care to an unconscious patient according to steps of procedure.

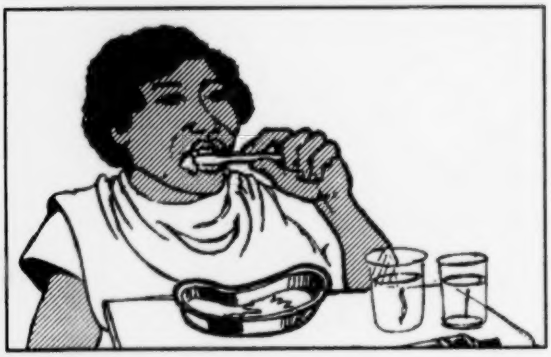
E. Clean dentures/false teeth according to steps of procedure.

Introduction

An important part of patient care is oral hygiene or mouth care. With good care, a patient's mouth will feel fresh and clean, thereby making food more appetizing and preventing bad breath.

Mouth care should be given to all patients after meals and at bedtime. Mouth care should be given to unconscious patients every two hours to keep the mouth moist.

In this unit, you will learn how to give mouth care to conscious and unconscious patients, and clean dentures.

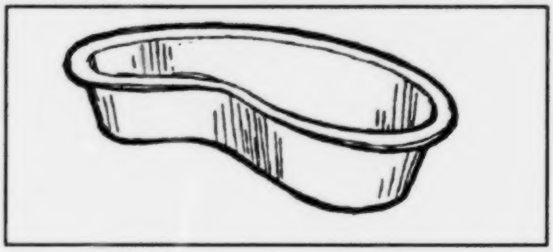


A. Terms

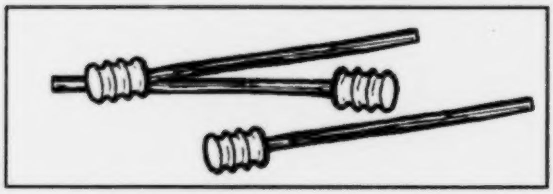
Conscious - condition of being awake and aware of surroundings

Unconscious - condition of being in a deep sleep or unresponsive

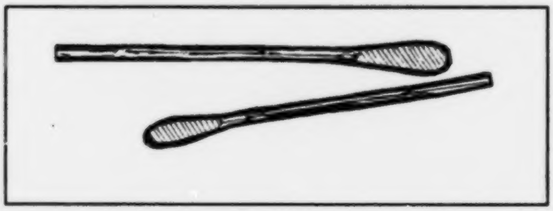
Emesis basin - pan into which a patient spits or vomits



Mouth swabs (Toothett)- sticks with sponge tips used for cleaning a patient's mouth



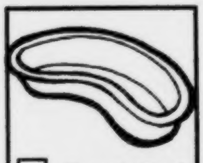
Lemon-glycerine swabs - mouth swabs coated with lemon glycerine used to keep a patient's mouth moist

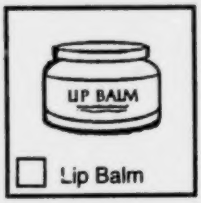


B. Steps of Procedure for Giving Mouth Care to a Conscious Patient Who Can Assist with Care

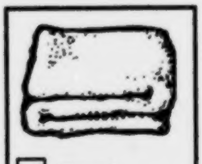
1. Wash your hands. Put on gloves.

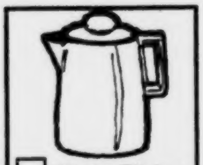
2. Assemble equipment.

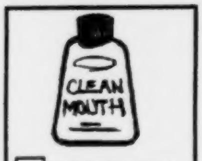

☐ Emesis Basin



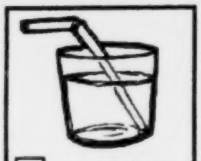
☐ Lip Balm

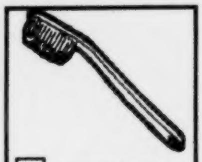

☐ Towel

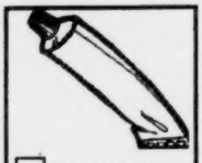

☐ Water Pitcher



☐ Mouthwash


☐ Cup & Straw

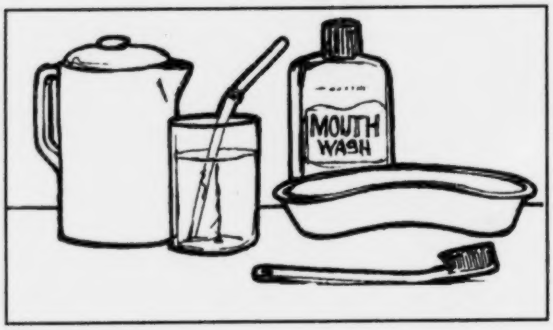

☐ Toothbrush


☐ Toothpaste

3. Identify and greet patient. Identify self.

4. Explain what you are going to do.

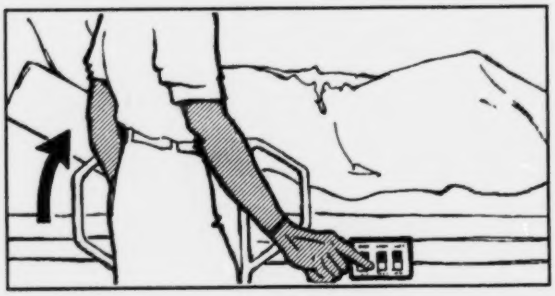
5. Bring equipment to bedside and place on overbed table.



NOTE: All of patient's mouth care equipment (toothbrush, cup, toothpaste) should be labeled with patient's name to prevent mixing up equipment. Mixing equipment can lead to an infection.

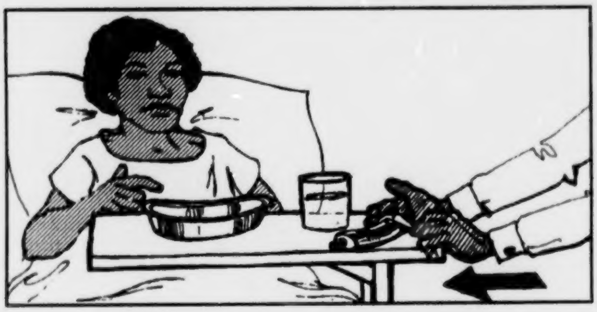
6. Provide privacy. Pull curtain around bed.

7. If patient is able to brush her own teeth, raise head of bed to sitting position or patient may be assisted to bathroom if able.

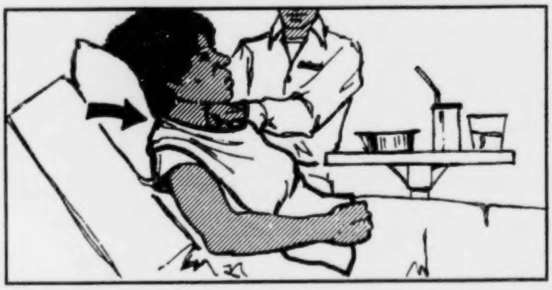


8. If patient is in bed, lower side rail.

9. Put overbed table across bed. Dilute mouthwash by mixing 1/2 water with 1/2 mouthwash.



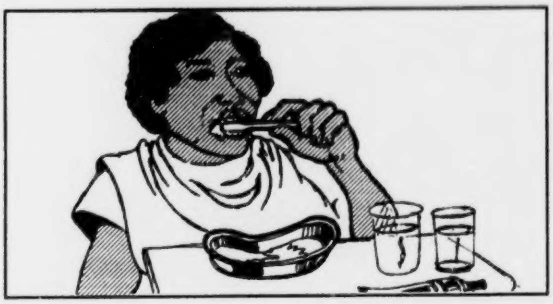
10. Spread towel across patient's chest to keep gown and sheets dry.



11. Pour water over toothbrush into emesis basin. Instruct or assist patient to put toothpaste on wet toothbrush.

12. Let patient brush her own teeth if patient is able.

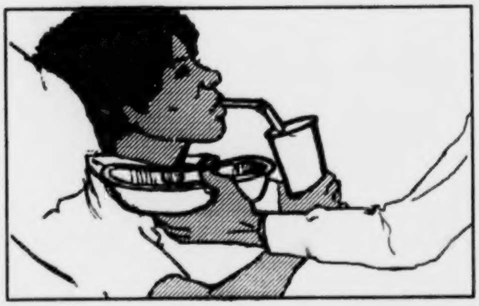
13. Tell patient to brush along gumline then brush teeth up and down in front and on both sides. The biting surfaces of the molars should be brushed with a back and forth motion. Assist patient if necessary.



14. Tell patient to brush the tongue gently. Assist if necessary.

15. Instruct or assist patient to rinse her mouth with water.

16. Hold emesis basin under patient's chin to allow patient to spit into it. Wipe lips.



17. Provide patient with mouthwash prepared earlier. (Patient may use a straw.)

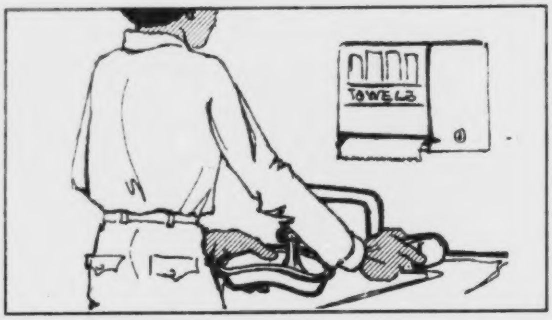
18. Tell patient to swish mouthwash around in mouth and spit it out. Tell patient not to swallow mouthwash.

19. Wipe patient's lips or have patient wipe own lips with towel. Apply lip balm to lubricate lips.

20. Make patient comfortable. Place call light within reach.

21. Pull up side rails if appropriate and open curtain.

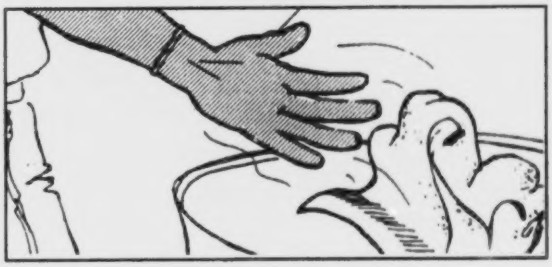
22. Empty emesis basin, rinse it with cold water, and dry it with a paper towel.



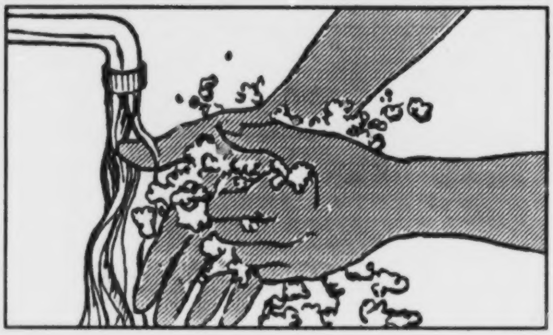
23. Return toothpaste, toothbrush, mouthwash, and emesis basin to bedside stand.

NOTE: Be sure caps on toothpaste and mouthwash are screwed on tightly.

24. Put towel with dirty linen.



25. Remove gloves and discard in appropriate container. Wash your hands. Wash patient's hands.

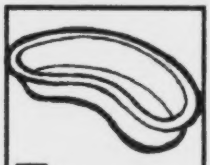


26. Record observations and report anything unusual to the charge nurse.

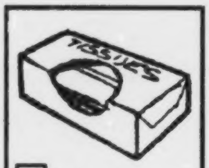
C. Steps of Procedure for Giving Mouth Care to a Conscious Patient Who Cannot Assist with Care

1. Wash your hands. Put on gloves.

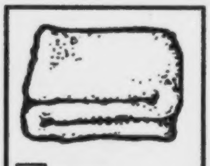
2. Assemble equipment.



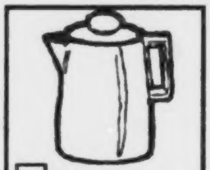
☐ Emesis Basin



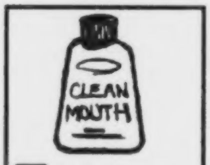
☐ Tissues



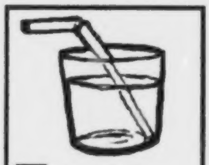
☐ Towel



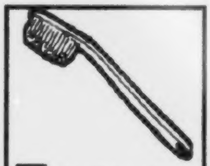
☐ Water Pitcher



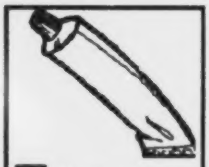
☐ Mouthwash



☐ Cup & Straw

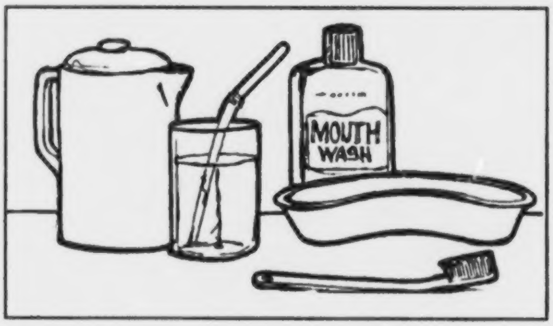


☐ Toothbrush



☐ Toothpaste

3. Bring equipment to bedside and place on overbed table.



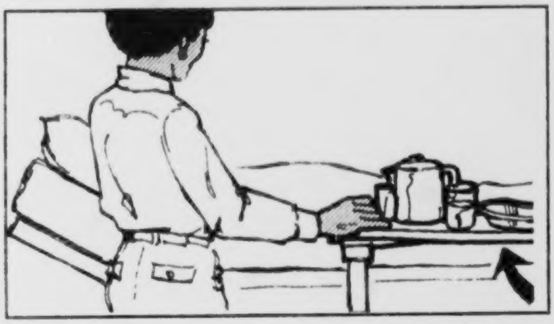
NOTE: All of patient's mouth care equipment (toothbrush, cup, toothpaste) should be labeled with patient's name to prevent mixing up equipment. Mixing equipment can lead to an infection.

4. Identify and greet patient. Identify self.

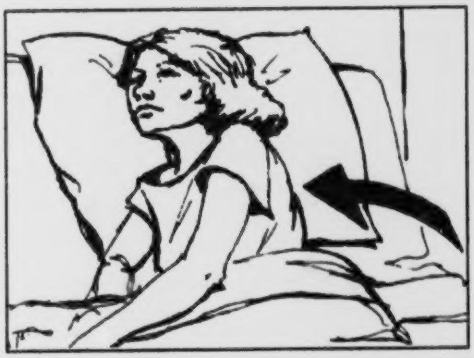
5. Explain what you are going to do.

6. Provide privacy. Pull curtain around bed.

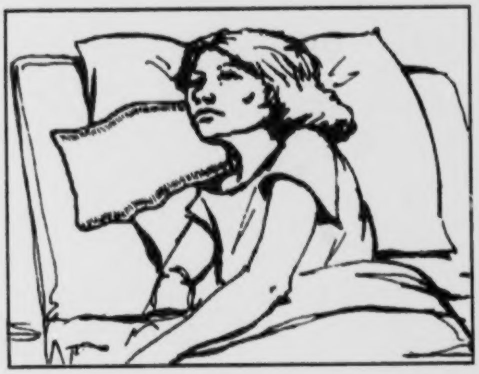
7. Place overbed table next to bed. Raise head of bed if allowed.



8. Assist or ask patient to turn on side toward you.

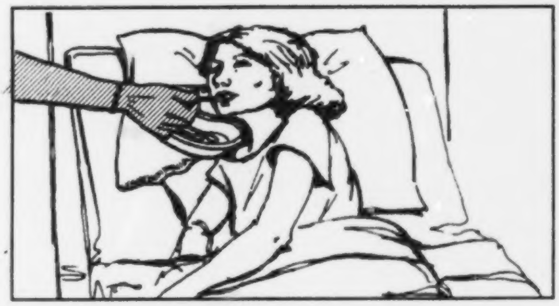


9. Place a towel on pillow and alongside patient's face.

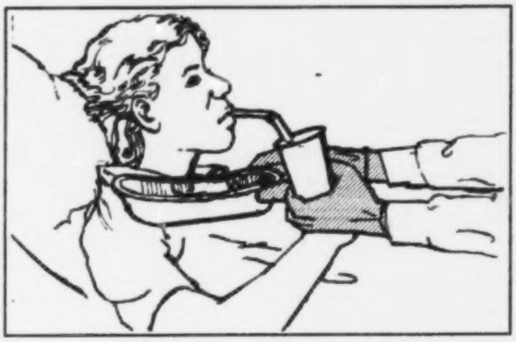


10. Pour water over toothbrush into emesis basin. Put toothpaste on wet toothbrush.

11. Hold emesis basin under patient's chin and brush patient's teeth. Brush up and down in front and on both sides. Brush the biting surfaces of the molars with a back and forth motion.



12. Help patient to rinse mouth; first with a cup of water, then with a mouthwash mixture of one-half mouthwash and one-half water.

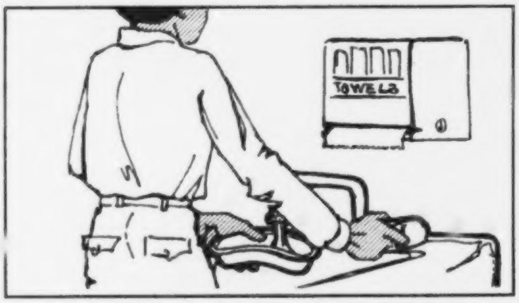


13. Wipe patient's mouth with towel when finished. Apply lip balm to lubricate lips.

14. Make patient comfortable. Place call light within reach.

15. Pull up side rails if appropriate and open curtain.

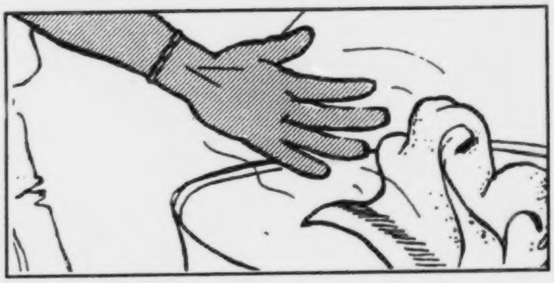
16. Take emesis basin into bathroom and rinse with cold water. Dry with a paper towel.



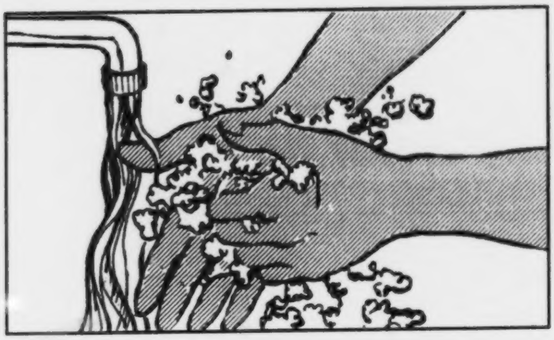
17. Return toothpaste, toothbrush, mouthwash, and emesis basin to bedside stand.

NOTE: Be sure caps on toothpaste and mouthwash are screwed on tightly.

18. Put towel with dirty linen.



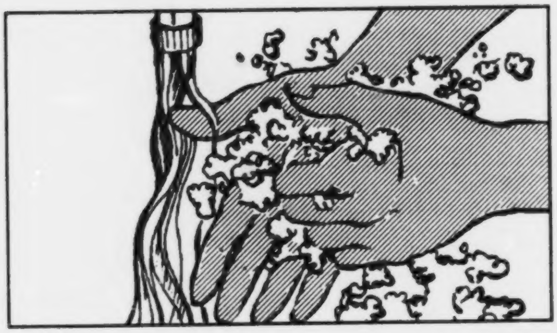
19. Remove gloves and discard in appropriate container. Wash your hands.



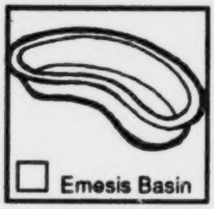
20. Record observations and report anything unusual to the charge nurse.

D. Steps of Procedure for Giving Mouth Care to an Unconscious Patient

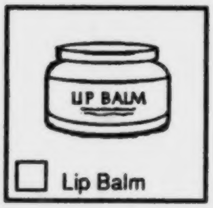
1. Wash your hands. Put on gloves.



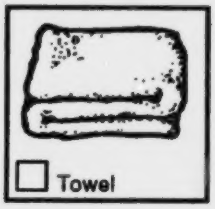
2. Assemble equipment.



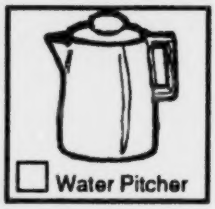
☐ Emesis Basin



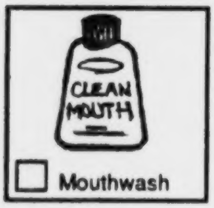
☐ Lip Balm



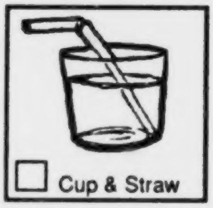
☐ Towel



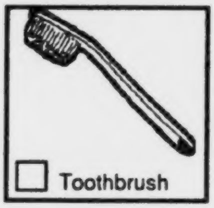
☐ Water Pitcher



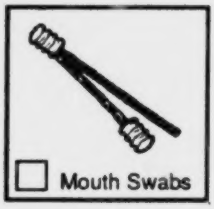
☐ Mouthwash



☐ Cup & Straw

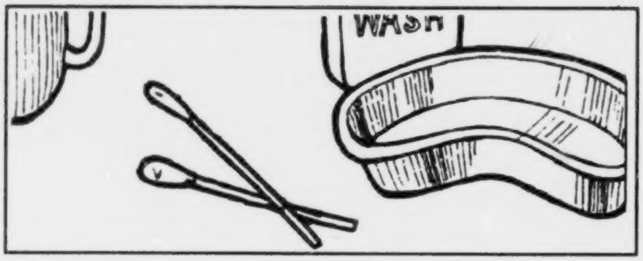


☐ Toothbrush



☐ Mouth Swabs

3. Bring equipment to bedside and place on overbed table.

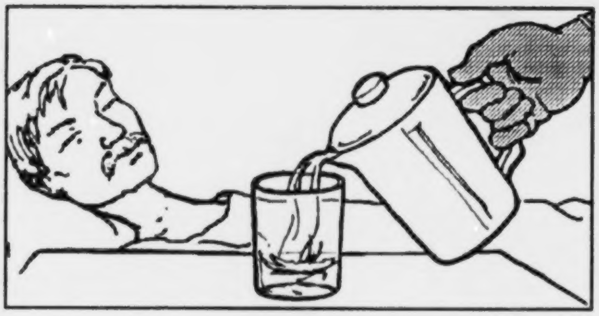


4. Identify and greet patient. Identify self.

5. Explain what you are going to do.

NOTE: Even though patient is unconscious, patient should be talked to as though patient is conscious.

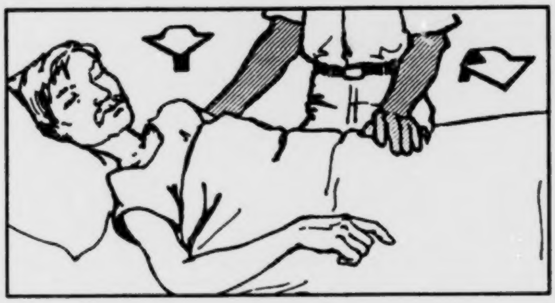
6. Mix a cup of one-half water and one-half mouthwash.



7. Provide privacy. Pull curtain around bed.

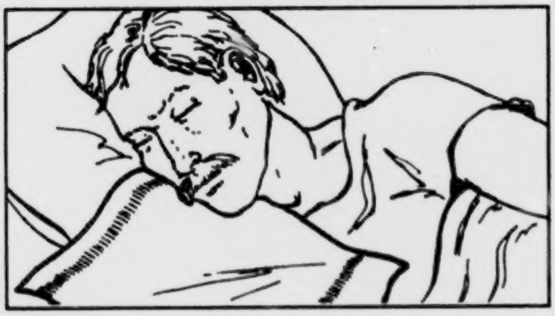
8. Lower side rail.

9. Turn patient on side toward you. Always keep the head turned to the side to allow secretions to drain from the mouth.

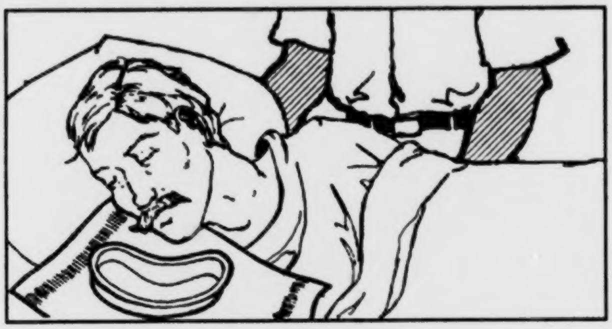


NOTE: Ask for help if you are unable to turn patient.

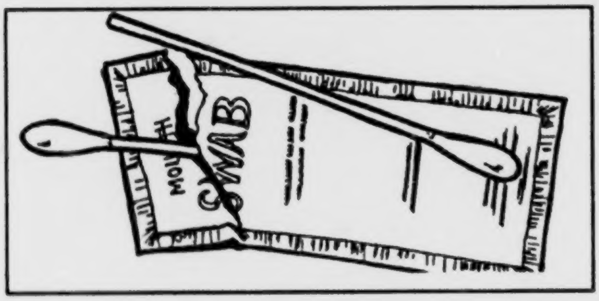
10. Place a towel on pillow and alongside patient's face.



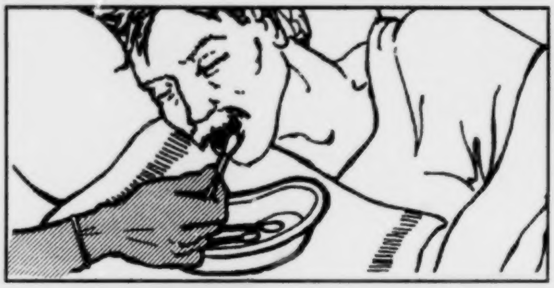
11. Put emesis basin on towel under patient's chin.



12. Open package of mouth swabs.

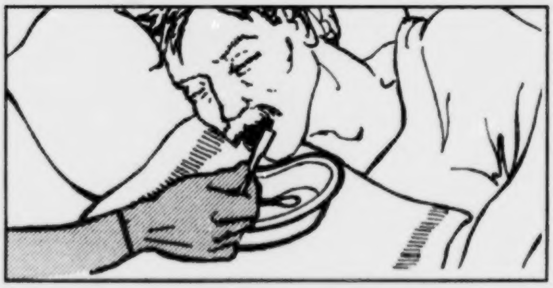


13. Gently open patient's mouth. Wipe inside of patient's mouth, including roof, tongue, inside cheeks, and lips with swab. Place used swab in emesis basin. Repeat as needed.



NOTE: If having difficulty opening patient's mouth, check with your instructor/supervisor.

14. Moisten toothbrush with diluted mouthwash. Brush gumline and teeth in up and down motion in front and on both sides. Hold emesis basin under patient's chin.



NOTE: Never pour liquid in unconscious patient's mouth.

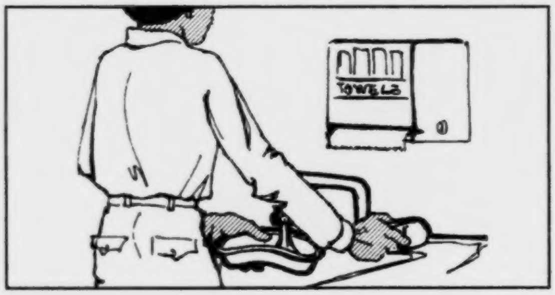
15. Wipe patient's lips with towel. Apply lip balm.

16. Remove emesis basin and towel.

17. Make patient comfortable. Place call light within reach.

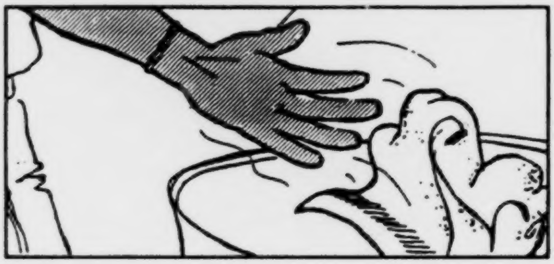
18. Pull up side rails if appropriate and open curtain.

19. Empty emesis basin, rinse with cold water, and dry it with a paper towel.

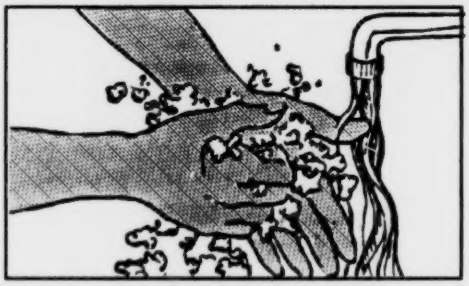


20. Return leftover swabs, toothbrush, mouthwash, and emesis basin to bedside stand.

21. Put towel with dirty linen.



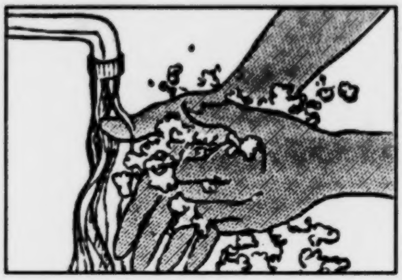
22. Remove gloves and discard in appropriate container. Wash your hands.



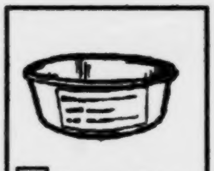
23. Record observations and report anything unusual to the charge nurse.

E. Steps of Procedure for Cleaning Dentures/False Teeth

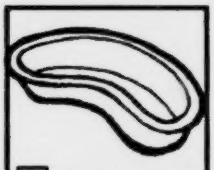
1. Wash your hands. Put on gloves.



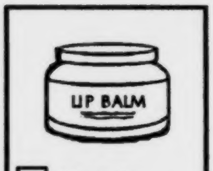
2. Assemble equipment.



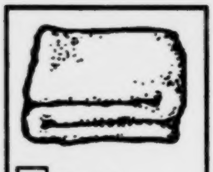
☐ Denture Cup



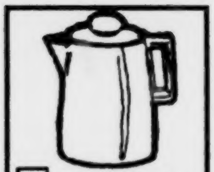
☐ Emesis Basin



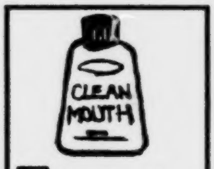
☐ Lip Balm



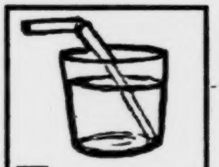
☐ Towel



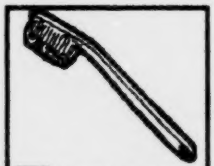
☐ Water Pitcher



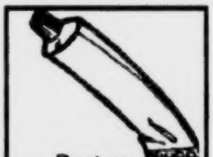
☐ Mouthwash



☐ Cup & Straw

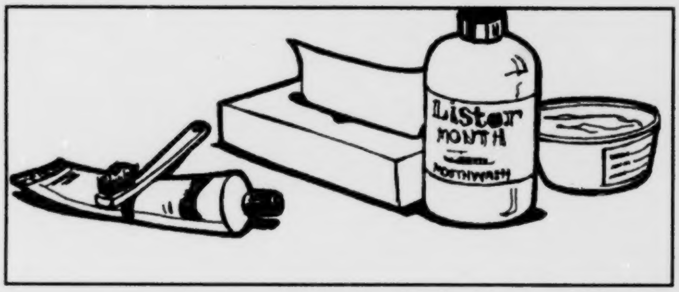


☐ Toothbrush



☐ Denture Cleanser

3. Bring equipment to patient's bedside. Dilute mouthwash by mixing 1/2 water with 1/2 mouthwash.

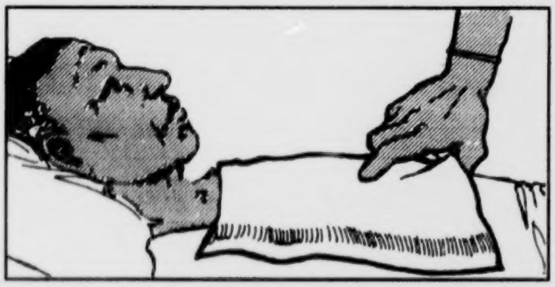


4. Identify and greet patient. Identify self.

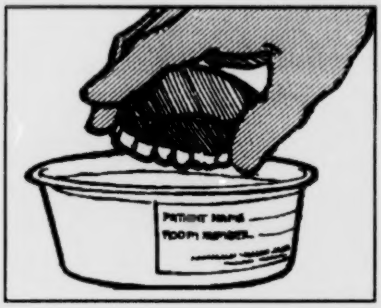
5. Explain what you are going to do.

6. Provide privacy. Pull curtain around bed.

7. Spread towel across patient's chest. Raise head of bed.



8. Ask patient to take out dentures and place them in denture cup. If patient needs assistance, run your fingers along the top of the upper gum as you gently push the denture forward and down. Lower dentures can be removed the same way along the lower gum line; push forward and up and place dentures in denture cup.



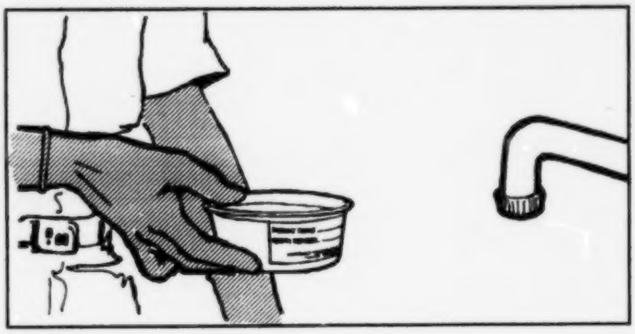
9. Provide water or diluted mouthwash to rinse the mouth of food particles.

10. Allow patient to spit into emesis basin or sink.

11. Have patient wipe mouth with towel or tissue.

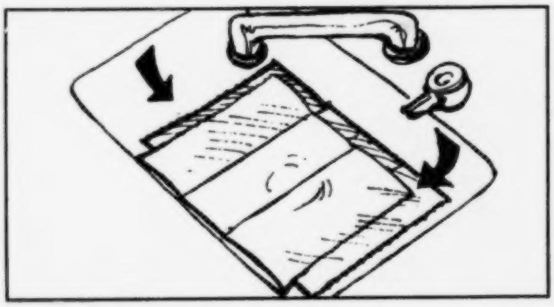
12. Apply lip balm to lubricate lips.

13. Take dentures in denture cup to sink.



CAUTION: Be very careful when handling dentures. They are easily broken if dropped and they are very expensive to replace.

14. Place clean washcloth or lay several paper towels in the sink, or fill sink one-half full with water to protect the dentures should they fall.

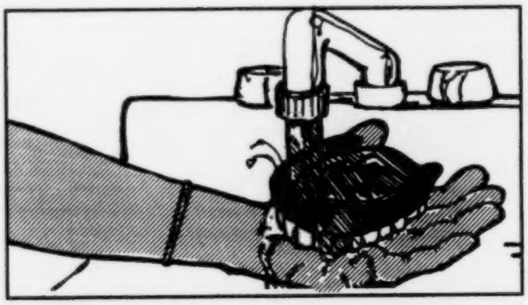


15. Put denture cleanser on wet toothbrush.

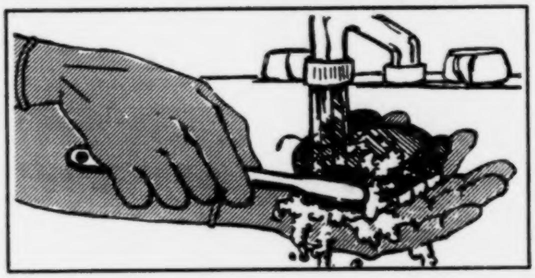
16. Turn on the cold water.

CAUTION: Never use hot water to clean or store dentures, it can cause warping.

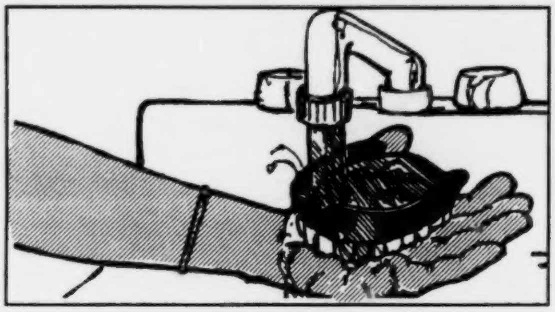
17. Take dentures out of denture cup and wet them.



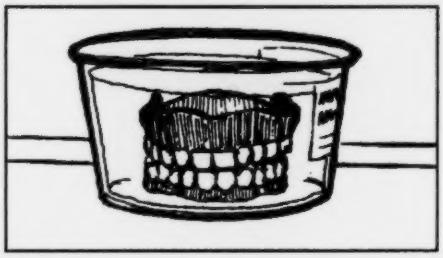
18. With dentures in palm of your hand, brush dentures until they are clean.



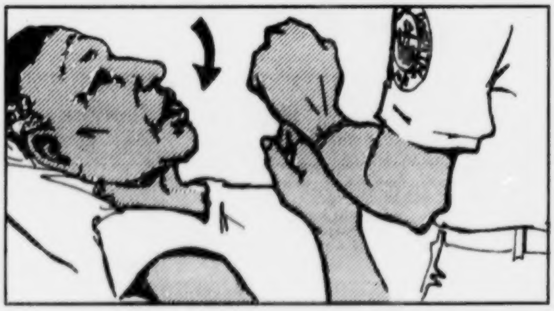
19. Rinse dentures well under cold water.



20. Place dentures in denture cup and bring to bedside.

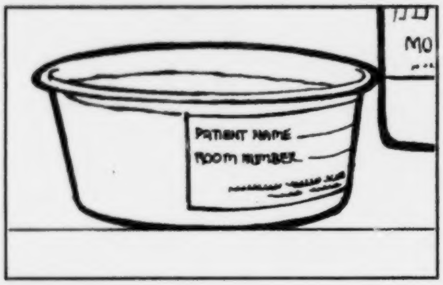


21. Allow patient to put dentures back in mouth. Assist if necessary. Remove towel.



NOTE: Put upper denture plate in first. If patient needs assistance, help him.

22. Put denture cup on overbed table, where patient can reach it. Fill denture cup with appropriate solution if patient is not going to wear dentures. This will prevent warping.

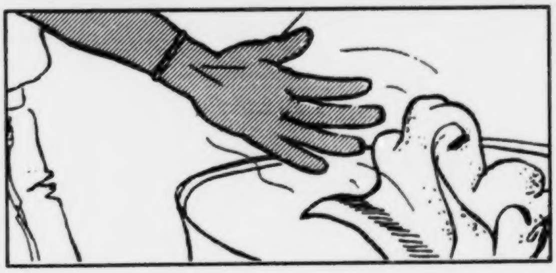


23. Make patient comfortable. Place call light within reach. Pull up side rails if appropriate.

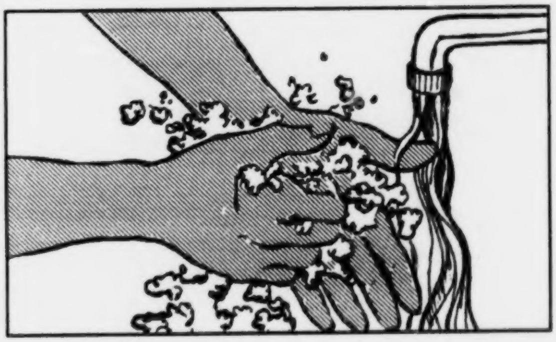
24. Clean and put away all equipment.

NOTE: Be sure denture cleanser and mouthwash caps are on tightly.

25. Put towel with dirty linen.



26. Remove gloves and discard in appropriate container. Wash your hands.



27. Record observation and report anything unusual to the charge nurse.

Mouth Care
Written Evaluation

Match terms in Column A with the definitions in Column B.

Column A

_____ 1. Unconscious

_____ 2. Mouth swabs

_____ 3. Conscious

_____ 4. Lemon-glycerine swabs

_____ 5. Emesis basin

Column B

a. Condition of being unable to move
b. Pan into which a patient spits or vomits
c. Sticks with sponge tips used for cleaning a patient's mouth
d. Condition of being in a deep sleep
e. Mouth swabs coated with lemon glycerine used to keep a patient's mouth moist
f. Condition of being awake and aware of things

Circle the letter that corresponds to the best answer.

6. Before putting clean dentures back into patient's mouth, you should help patient to:

   a. Rinse mouth with water and mouthwash.
   b. Put away mouth cleaning equipment.
   c. Soak dentures in denture cup.
   d. Put solution in denture cup.

7. Mouth care should be given to a conscious patient:

   a. One time a day.
   b. After meals and at bedtime.
   c. First thing in the morning before breakfast.
   d. When they ask for it.

8. The unconscious patient should be given mouth care:

   a. Every 2 hours.
   b. Every 4 hours.
   c. Once on each shift.
   d. Every morning.

Mouth Care
Evaluation

____________________ has successfully performed the following steps of procedure.
(Student)

Giving Mouth Care to a Conscious Patient Who Can Assist With Care		**Yes**	**No**	**Comments**
1.	Wash your hands. Put on gloves.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Bring equipment to bedside and place on overbed table. **NOTE:** All of patient's mouth care equipment (toothbrush, cup, toothpaste) should be labeled with patient's name to prevent mixing up equipment. Mixing equipment can lead to an infection.			
6.	Provide privacy. Pull curtain around bed.			
7.	If patient is able to brush her own teeth, raise head of bed to sitting position or patient may be assisted to bathroom if able.			
8.	If patient is in bed, lower side rail.			
9.	Put overbed table across bed. Dilute mouthwash by pouring a cup of one-half water and one-half mouthwash.			
10.	Spread towel across patient's chest to keep gown and sheets dry.			
11.	Pour water over toothbrush into emesis basin. Instruct or assist patient to put toothpaste on wet toothbrush.			
12.	Let patient brush her own teeth if patient is able.			
13.	Tell patient to brush along gumline then brush teeth up and down in front and on both sides. The biting surfaces of the molars should be brushed with a back and forth motion. Assist patient if necessary.			
14.	Tell patient to brush the tongue gently. Assist if necessary.			
15.	Instruct or assist patient to rinse her mouth with water.			
16.	Hold emesis basin under patient's chin to allow patient to spit into it. Wipe lips.			
17.	Provide patient with mouthwash prepared earlier. (Patient may use a straw.)			
18.	Tell patient to swish mouthwash around in mouth and spit it out. Tell patient not to swallow mouthwash.			
19.	Wipe patient's lips or have patient wipe own lips with towel. Apply lip balm to lubricate lips.			

	Giving Mouth Care to a Conscious Patient Who Can Assist With Care Cont.	Yes	No	Comments
20.	Make patient comfortable. Place call light within reach.			
21.	Pull up side rails if appropriate and open curtain.			
22.	Empty emesis basin, rinse it with cold water, and dry it with a paper towel.			
23.	Return toothpaste, toothbrush, mouthwash, and emesis basin to bedside stand. **NOTE:** Be sure caps on toothpaste and mouthwash are screwed on tightly.			
24.	Put towel with dirty linen.			
25.	Remove gloves and discard in appropriate container. Wash your hands. Wash patient's hands.			
26.	Record observations and report anything unusual to the charge nurse.			
	Giving Mouth Care to a Conscious Patient Who Cannot Assist With Care			
1.	Wash your hands. Put on gloves.			
2.	Assemble equipment.			
3.	Bring equipment to bedside and place on overbed table. **NOTE:** All of patient's mouth care equipment (toothbrush, cup, toothpaste) should be labeled with patient's name to prevent mixing up equipment. Mixing equipment can lead to an infection.			
4.	Identify and greet patient. Identify self.			
5.	Explain what you are going to do.			
6.	Provide privacy. Pull curtain around bed.			
7.	Place overbed table next to bed. Raise head of bed if allowed.			
8.	Assist or ask patient to turn on side toward you.			
9.	Place a towel on pillow and alongside patient's face.			
10.	Pour water over toothbrush into emesis basin. Put toothpaste on wet toothbrush.			
11.	Hold emesis basin under patient's chin and brush patient's teeth. Brush up and down in front and on both sides. Brush the biting surfaces of the molars with a back and forth motion.			
12.	Help patient to rinse mouth, first with a cup of water, then with a mouthwash mixture of one-half mouthwash and one-half water.			
13.	Wipe patient's mouth with towel when finished. Apply lip balm to lubricate lips.			
14.	Make patient comfortable. Place call light within reach.			
15.	Pull up side rails if appropriate and open curtain.			
16.	Take emesis basin into bathroom and rinse with cold water. Dry with a paper towel.			

Giving Mouth Care to a Conscious Patient Who Cannot Assist With Care Cont.		**Yes**	**No**	**Comments**
17.	Return toothpaste, toothbrush, mouthwash, and emesis basin to bedside stand. **NOTE:** Be sure caps on toothpaste and mouthwash are screwed on tightly.			
18.	Put towel with dirty linen.			
19.	Remove gloves and discard in appropriate container. Wash your hands.			
20.	Record observations and report anything unusual to the charge nurse.			
Giving Mouth Care to an Unconscious Patient				
1.	Wash your hands. Put on gloves.			
2.	Assemble equipment.			
3.	Bring equipment to bedside and place on overbed table.			
4.	Identify and greet patient. Identify self.			
5.	Explain what you are going to do. **NOTE:** Even though patient is unconscious, patient should be talked to as though patient is conscious.			
6.	Mix a cup of one-half water and one-half mouthwash.			
7.	Provide privacy. Pull curtain around bed.			
8.	Lower side rail.			
9.	Turn patient on side toward you. Always keep the head turned to the side to allow secretions to drain from the mouth. **NOTE:** Ask for help if you are unable to turn patient.			
10.	Place a towel on pillow and alongside patient's face.			
11.	Put emesis basin on towel under patient's chin.			
12.	Open package of mouth swabs.			
13.	Gently open patient's mouth. Wipe inside of patient's mouth, including roof, tongue, inside cheeks, and lips with swab. Place used swab in emesis basin. Repeat as needed. **NOTE:** If having difficulty opening patient's mouth, check with your instructor/ supervisor.			
14.	Moisten toothbrush with diluted mouthwash. Brush gumline and teeth in up and down motion in front and on both sides. Hold emesis basin under patient's chin. **NOTE:** Never pour liquid in unconscious patient's mouth.			
15.	Wipe patient's lips with towel. Apply lip balm.			
16.	Remove emesis basin and towel.			
17.	Make patient comfortable. Place call light within reach.			
18.	Pull up side rails if appropriate and open curtain.			
19.	Empty emesis basin, rinse with cold water, and dry it with a paper towel.			

Giving Mouth Care to an Unconscious Patient Cont.		Yes	No	Comments
20.	Return leftover swabs, toothbrush, mouthwash, and emesis basin to bedside stand.			
21.	Put towel with dirty linen.			
22.	Remove gloves and discard in appropriate container. Wash your hands.			
23.	Record observations and report anything unusual to the charge nurse.			
Cleaning Dentures/False Teeth				
1.	Wash your hands. Put on gloves.			
2.	Assemble equipment.			
3.	Bring equipment to patient's bedside. Dilute mouthwash by mixing 1/2 water with 1/2 mouthwash.			
4.	Identify and greet patient. Identify self.			
5.	Explain what you are going to do.			
6.	Provide privacy. Pull curtain around bed.			
7.	Spread towel across patient's chest. Raise head of bed.			
8.	Ask patient to take out dentures and place them in denture cup. If patient needs assistance, run your fingers along the top of the upper gum as you gently push the denture forward and down. Lower dentures can be removed the same way along the lower gum line; push forward and up and place dentures in denture cup.			
9.	Provide water or diluted mouthwash to rinse the mouth of food particles.			
10.	Allow patient to spit into emesis basin or sink.			
11.	Have patient wipe mouth with towel or tissue.			
12.	Apply lip balm to lubricate lips.			
13.	Take dentures in denture cup to the sink. **CAUTION:** Be very careful when handling dentures. They are easily broken if dropped and they are very expensive to replace.			
14.	Place clean washcloth or lay several paper towels in the sink, or fill sink one-half full with water to protect the dentures should they fall.			
15.	Put denture cleanser on wet toothbrush.			
16.	Turn on the cold water. **CAUTION:** Never use hot water to clean or store dentures, it can cause warping.			
17.	Take dentures out of denture cup and wet them.			
18.	With dentures in palm of your hand, brush dentures until they are clean.			
19.	Rinse dentures well under cold water.			
20.	Place dentures in denture cup and bring to bedside.			

Cleaning Dentures/False Teeth Cont.		Yes	No	Comments
21.	Allow patient to put dentures back in mouth. Assist if necessary. Remove towel. **NOTE:** Put upper denture plate in first. If patient needs assistance, help him.			
22.	Put denture cup on overbed table, where patient can reach it. Fill denture cup with appropriate solution if patient's not going to wear dentures. This will prevent warping.			
23.	Make patient comfortable. Place call light within reach. Pull up side rails if appropriate.			
24.	Clean and put away all equipment. **NOTE:** Be sure denture cleanser and mouthwash caps are on tightly.			
25.	Put towel with dirty linen.			
26.	Remove gloves and discard in appropriate container. Wash your hands.			
27.	Record observation and report anything unusual to the charge nurse.			

Student's Signature/Date

Instructor's Signature/Date

Shaving

Unit Objective

After completing this unit, you should be able to shave a male patient with a safety or electric razor.

Specific Objectives

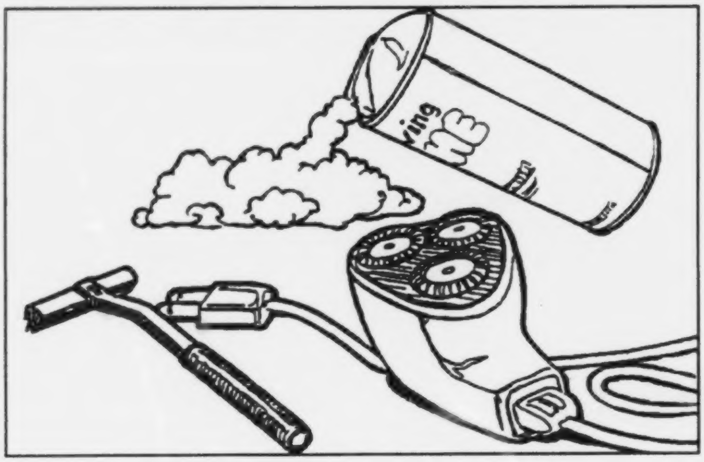
After completing this unit you should be able to:

- A. Match terms in this unit with their correct definitions.
- B. Shave a patient's face using a safety razor according to steps of procedure.
- C. Shave a patient's face using an electric razor according to steps of procedure.

Introduction

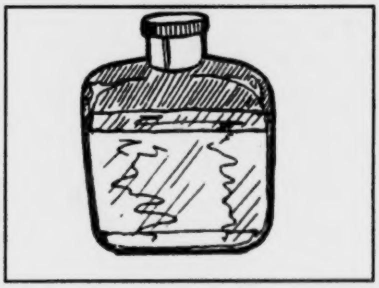
Shaving is a regular morning activity for most men. Some female patients may have excessive facial hair and request shaving. Sometimes a patient is well enough to shave himself. If this is the case, all you need to do is provide necessary equipment. If a patient is too ill or too weak to shave, you will need to do it for him. Shaving can be done with an electric or a safety razor.

In this unit, you will learn how to shave a patient using an electric and a safety razor.

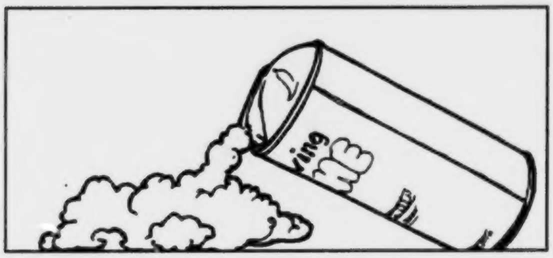


A. Terms

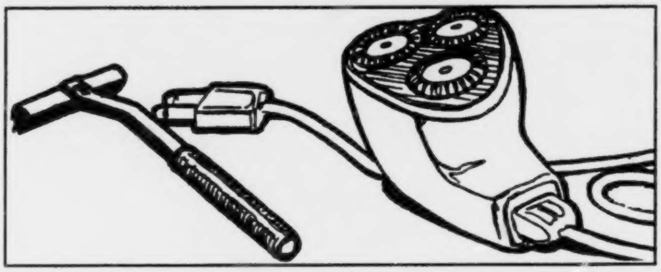
Pre-shaving lotion - liquid used to moisten facial hair and soothe skin when shaving with an electric razor



Shaving cream - creamy substance used to moisten facial hair and soothe skin when shaving with a safety razor



Razor - shaving instrument, either safety razor or electric razor, used to cut off facial hair



B. Steps of Procedure for Shaving a Patient's Face With a Safety Razor

1. Assemble equipment.

☐ Basin of Warm Water

☐ Shaving Cream

☐ Safety Razor

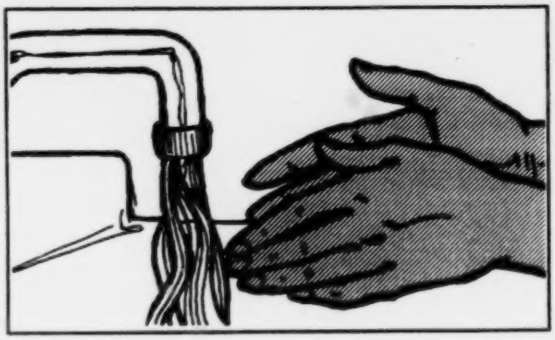
☐ Towel

☐ Washcloth

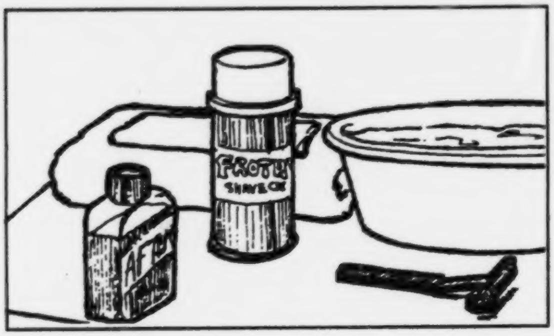
☐ After-Shave

☐ Gloves

2. Wash your hands. Put on gloves.



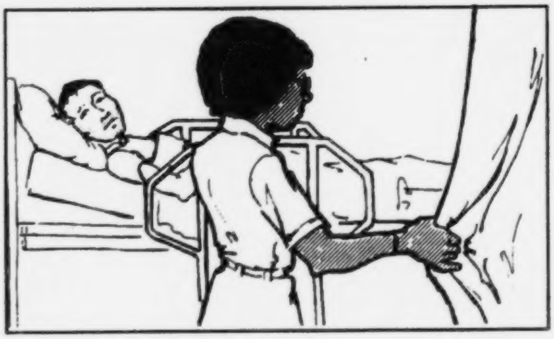
3. Bring shaving equipment to overbed table.



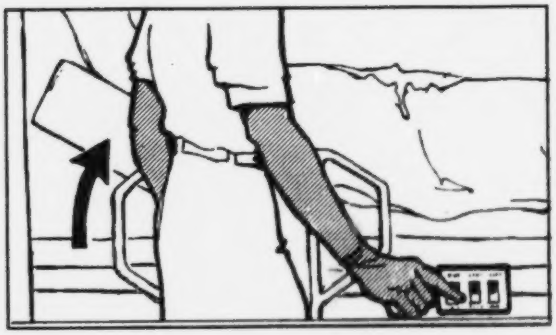
4. Identify and greet patient. Identify self.

5. Explain what you are going to do.

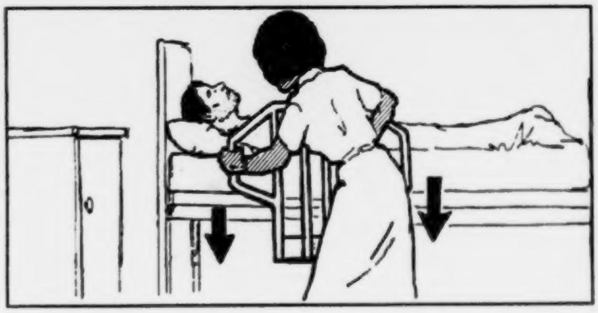
6. Provide privacy. Pull curtain around bed.



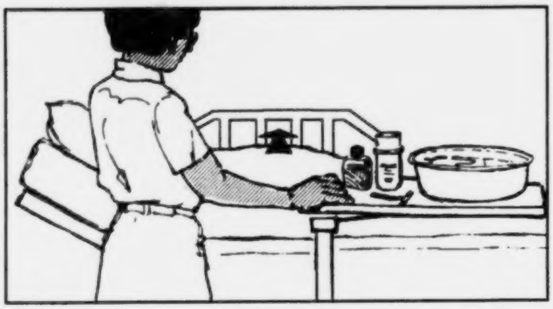
7. Raise head of bed, if allowed, or position patient in a chair in a well-lighted area.



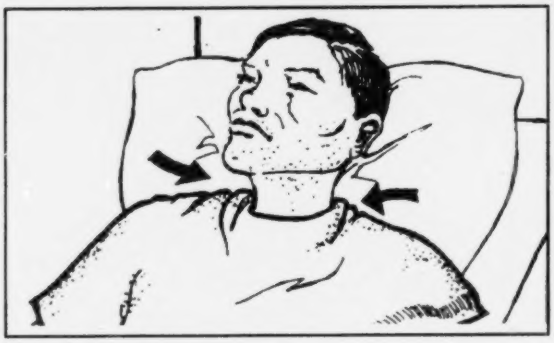
8. If patient is in bed, lower side rail.



9. Pull overbed table across bed or chair.

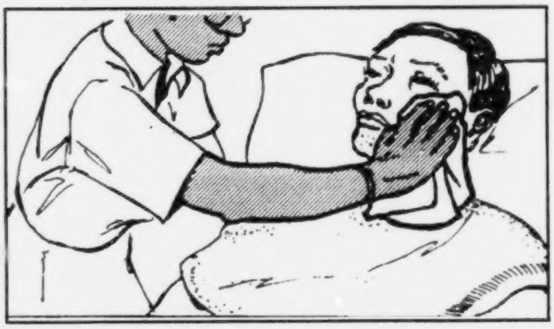


10. Spread towel under patient's chin.

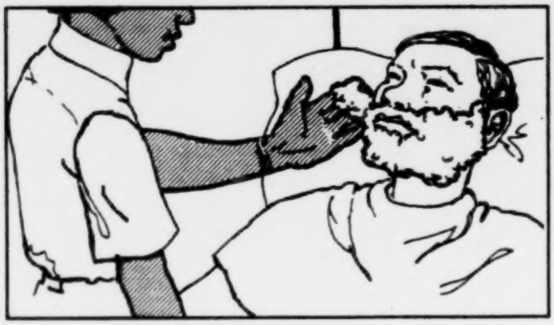


11. Wet patient's face with warm water.

NOTE: Warm water softens the beard and makes shaving smoother.

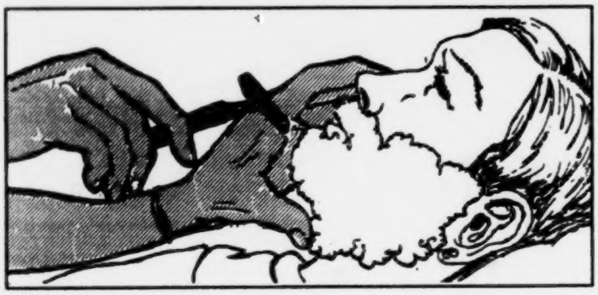


12. Apply shaving cream to the face. Use a generous amount.

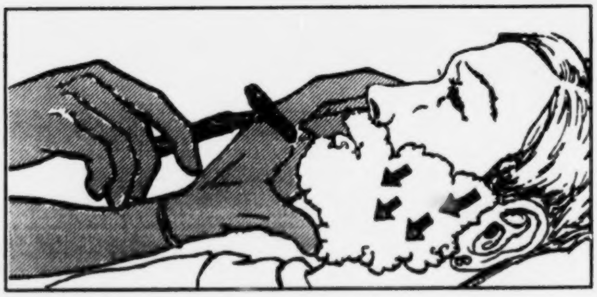


13. Leave lather in place about 15-20 seconds.

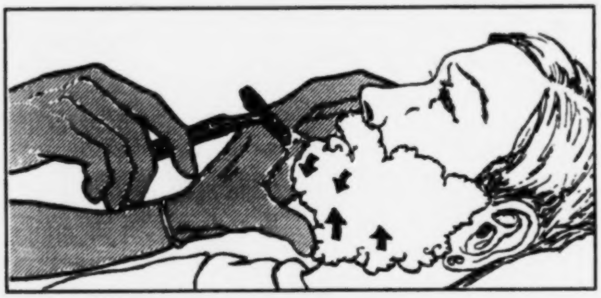
14. Using the fingers of one hand, hold skin tight and begin to shave in the direction that the hairs grow.



15. Start stroking downward with razor under sideburns and work downward over cheeks. Use short, firm strokes. Rinse razor often in water.

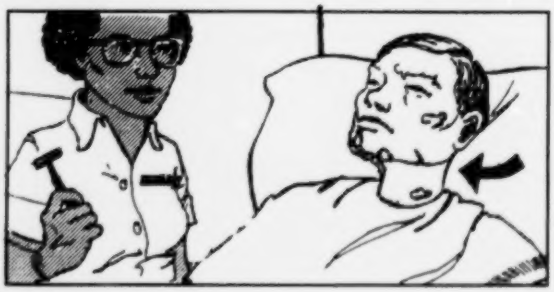


16. Continue shaving over the chin. Work upward on neck under chin.



17. Shave area around the lips carefully.

NOTE: You may need to stretch skin gently to shave in creases and sensitive areas.

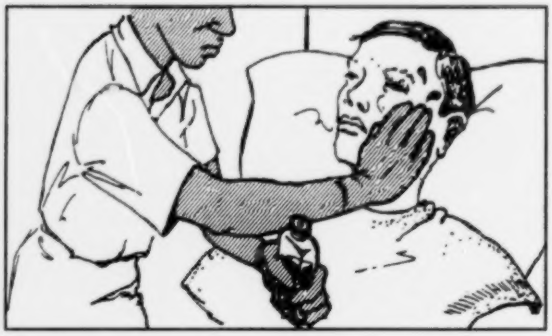


18. If you cut the patient's skin, be sure to report it to your supervisor, especially if bleeding doesn't stop after applying pressure.

NOTE: Apply pressure with tissue or washcloth to stop bleeding.

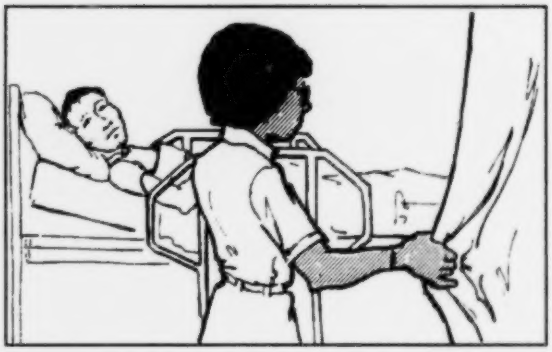
19. Wash off remaining shaving cream when you have finished shaving. Gently pat face dry with towel.

20. Apply after-shave lotion if patient requests it or if it is part of his usual routine.

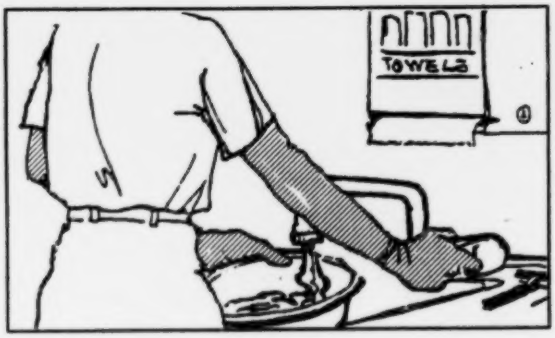


21. Make patient comfortable. Place call light within reach.

22. Pull up side rails if appropriate and open curtain.

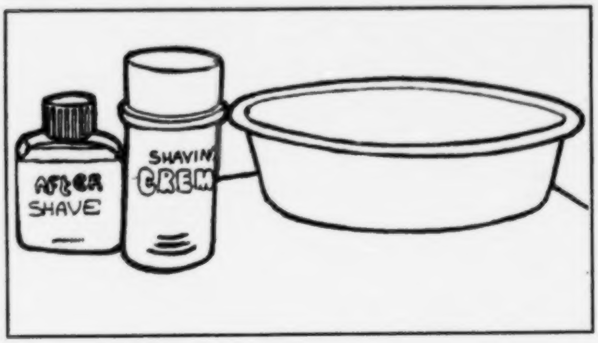


23. Empty, rinse, and dry water basin.

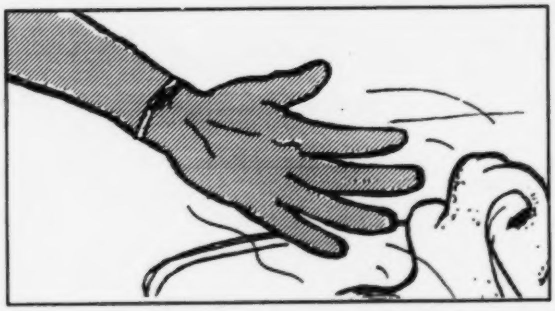


24. Return basin, shaving cream, and after-shave lotion to their proper places.

NOTE: Dispose of safety razor in sharps container.

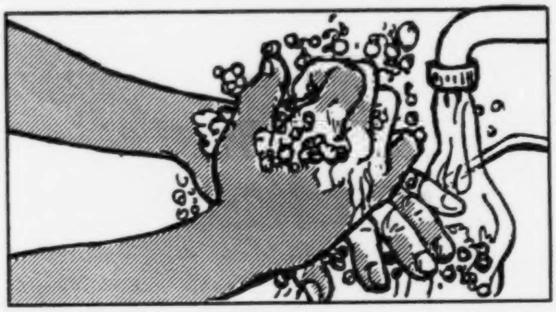


25. Put dirty towel and washcloth with dirty linen.



26. Remove and discard gloves in appropriate container.

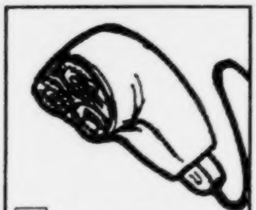
27. Wash your hands.



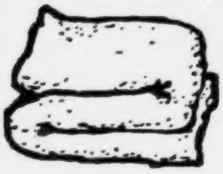
28. Report anything unusual to the charge nurse.

C. Steps of Procedure for Shaving a Patient's Face With an Electric Razor

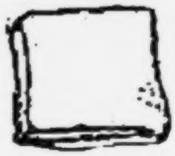
1. Assemble equipment.


☐ Electric Razor

☐ Pre-Shaving Lotion


☐ Towel

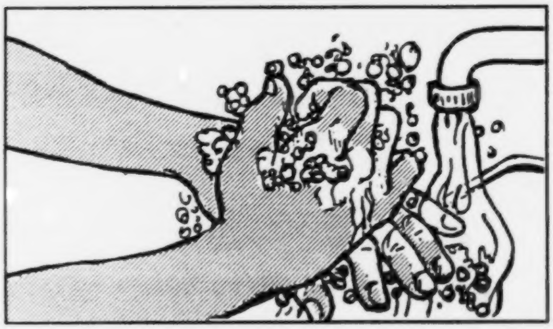
☐ After-shave Lotion


☐ Washcloth

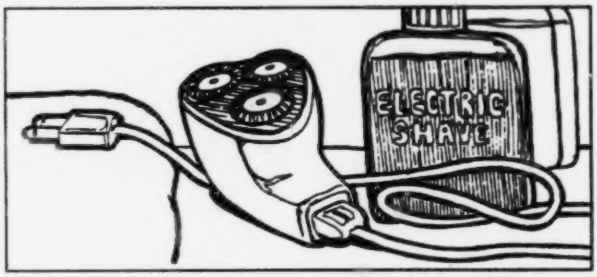
☐ Basin of Warm Water

☐ Soap

2. Wash your hands.



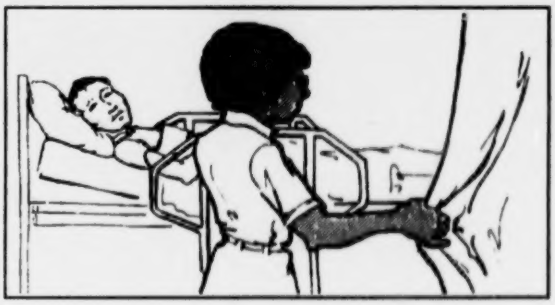
3. Bring electric razor, shaving lotions, basin, soap, washcloth, and towel to bedside.



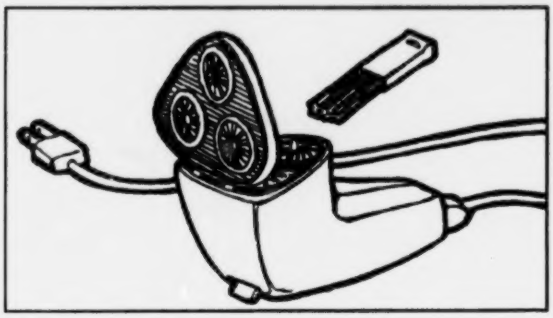
4. Identify and greet patient. Identify self.

5. Explain what you are going to do.

6. Provide privacy. Pull curtain around bed.

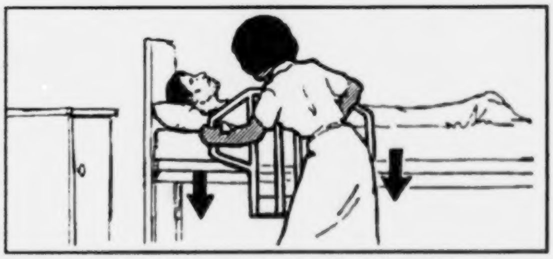


7. Clean razor head.

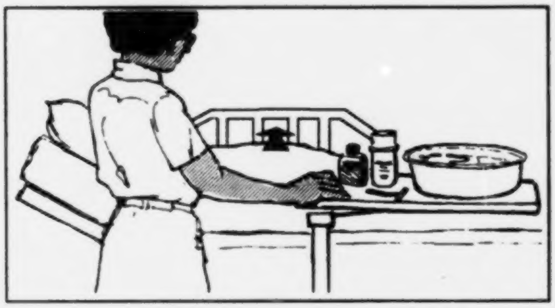


8. Raise head of bed, if allowed, or position patient in chair in a well-lighted area.

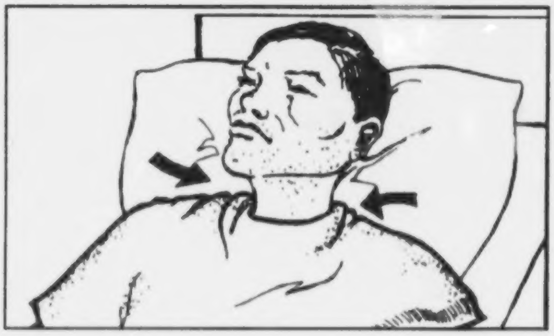
9. If patient is in bed, lower side rail.



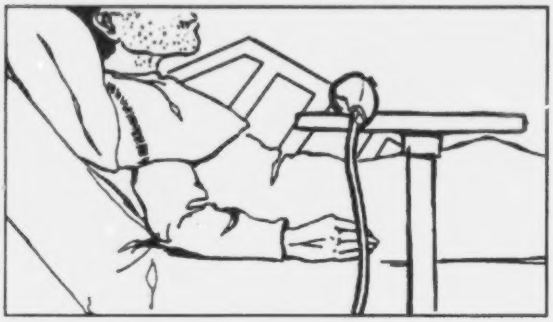
10. Pull overbed table across bed or chair.



11. Spread towel under patient's chin.



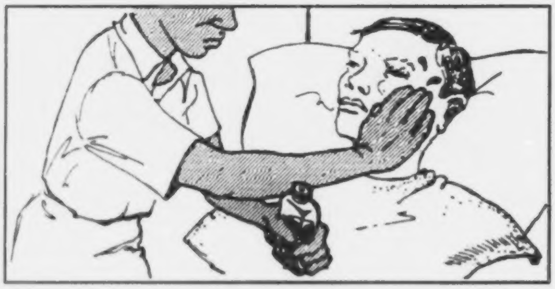
12. Plug in razor and place it on overbed table.



NOTE: Be sure your hands are dry before plugging in razor.

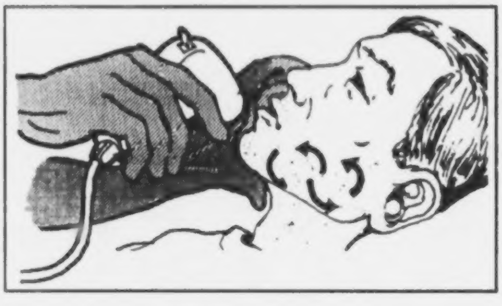
13. Wash face thoroughly with soap and water to remove dirt and oil. Rinse with warm water.

14. Apply pre-shaving lotion to patient's face, if patient requests it or if it is part of his usual routine.

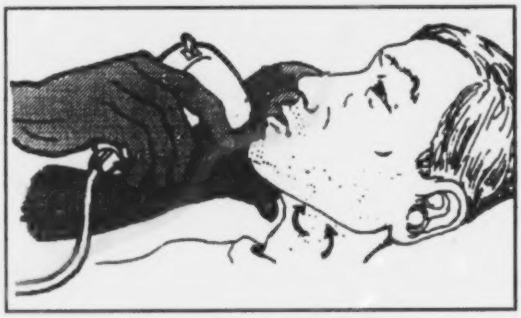


15. Turn on razor.

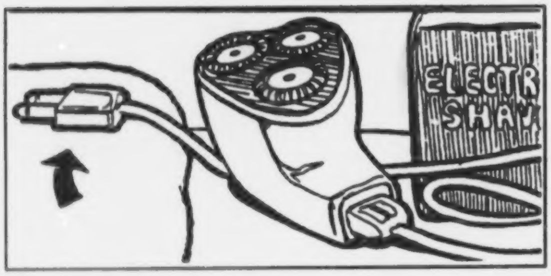
16. Start shaving from sideburns holding skin tightly and shaving in a circular motion over patient's face.



17. Using a circular motion, shave upward on neck, under chin, and around mouth.

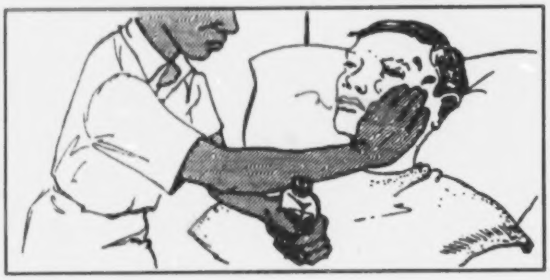


18. Turn off razor and unplug when finished.

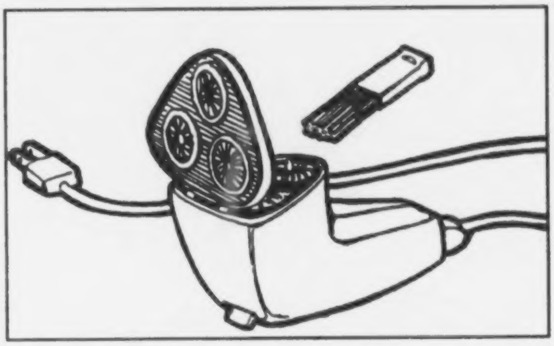


NOTE: Be sure your hands are dry before unplugging razor.

19. Apply after-shave lotion if patient requests it or if it is part of his usual routine.

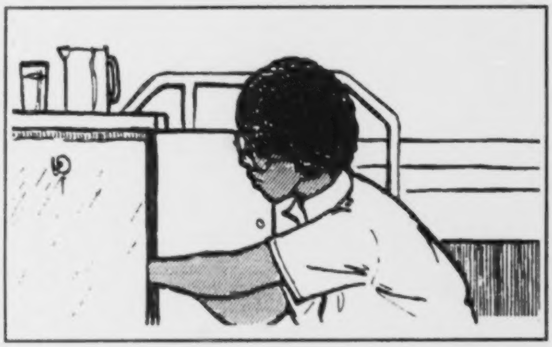


20. Take blades out of razor and clean as directed.



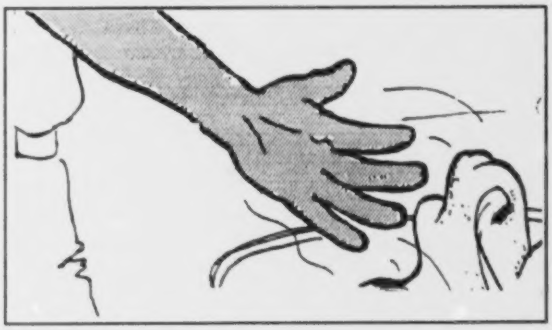
NOTE: Check with your supervisor. Patient may be able to tell you how to clean it.

21. Make patient comfortable. Place call light within reach.
22. Pull up side rails if appropriate and open curtain.
23. Put away razor and shaving lotions.

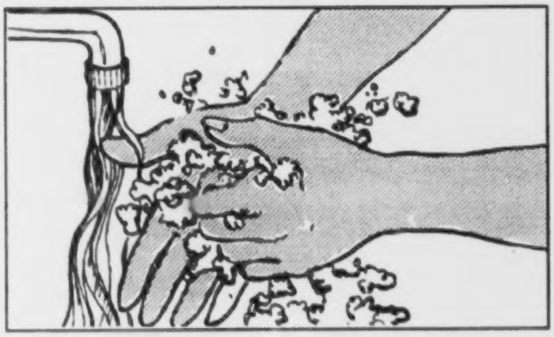


NOTE: Be sure caps are screwed tightly on shaving lotions.

24. Place towel and washcloth with dirty linen.



25. Wash your hands.



27. Report anything unusual to your supervisor, including any sores on patient's face or neck and nicks or cuts.

Shaving

Written Evaluation

Match terms in Column A with definitions in Column B.

Column A	**Column B**
_____ 1. Pre-shaving lotion	a. Creamy substance used to moisten facial hair and soothe skin when shaving with a safety razor
_____ 2. Razor	b. Liquid used to moisten facial hair and soothe skin when shaving with an electric razor
_____ 3. Shaving cream	c. Shaving instrument, either safety or electric, used to cut facial hair

Circle letter that corresponds to the best answer.

4. Before applying shaving cream to a patient's face, you should:

   a. Wet the face with warm water.
   b. Wet the face with cold water.
   c. Wet the face with hot water.
   d. Wet the face with a washcloth.

5. When shaving a patient, use:

   a. Long, soft strokes.
   b. Medium, firm strokes.
   c. Short, firm strokes.
   d. Downward strokes only.

6. If you cut a patient's skin while shaving him, you should:

   a. Report it to your supervisor.
   b. Cover the cuts with band-aids.
   c. Cover the patient's face with a towel.
   d. Ignore it and go on.

7. When shaving a patient with an electric razor, you should:

   a. Shave straight downward.
   b. Shave straight upward.
   c. Use a circular motion.
   d. Shave sideways.

Shaving
Evaluation

________________________ has successfully performed the following steps of procedure
(Student)

Shaving a Patient's Face With a Safety Razor		Yes	No	Comments
1.	Assemble equipment.			
2.	Wash your hands. Put on gloves.			
3.	Bring shaving equipment to overbed table.			
4.	Identify and greet patient. Identify self.			
5.	Explain what you are going to do.			
6.	Provide privacy. Pull curtain around bed.			
7.	Raise head of bed, if allowed, or position patient in a chair in a well-lighted area.			
8.	If patient is in bed, lower side rail.			
9.	Pull overbed table across bed or chair.			
10.	Spread towel under patient's chin.			
11.	Wet patient's face with warm water. **NOTE:** Warm water softens the beard and makes shaving smoother.			
12.	Apply shaving cream to the face. Use a generous amount.			
13.	Leave lather in place about 15-20 seconds.			
14.	Using the fingers of one hand, hold skin tight and begin to shave in the direction that the hairs grow.			
15.	Start stroking downward with razor under sideburns and work downward over cheeks. Use short, firm strokes. Rinse razor often in water.			
16.	Continue shaving over the chin. Work upward on neck under chin.			
17.	Shave area around the lips carefully. **NOTE:** You may need to stretch skin gently to shave in creases and sensitive areas.			
18.	If you cut the patient's skin, be sure to report it to your supervisor, especially if bleeding doesn't stop after applying pressure. **NOTE:** Apply pressure with tissue or washcloth to stop bleeding.			
19.	Wash off remaining shaving cream when you have finished shaving. Gently pat face dry with towel.			
20.	Apply after-shave lotion if patient requests it or if it is part of his usual routine.			

Shaving With a Safety Razor Cont.		Yes	No	Comments
21.	Make patient comfortable. Place call light within reach.			
22.	Pull up side rails if appropriate and open curtain.			
23.	Empty, rinse, and dry water basin.			
24.	Return basin, shaving cream, and after-shave lotion to their proper places. **NOTE:** Dispose of safety razor in sharps container.			
25.	Put dirty towel and washcloth with dirty linen.			
26.	Remove and discard gloves in appropriate container.			
27.	Wash your hands.			
28.	Report anything unusual to the charge nurse.			
Shaving a Patient's Face With an Electric Razor				
1.	Assemble equipment.			
2.	Wash your hands.			
3.	Bring electric razor, shaving lotions, basin, soap, washcloth, and towel to bedside.			
4.	Identify and greet patient. Identify self.			
5.	Explain what you are going to do.			
6.	Provide privacy. Pull curtain around bed.			
7.	Clean razor head.			
8.	Raise head of bed, if allowed, or position patient in chair in a well-lighted area.			
9.	If patient is in bed, lower side rail.			
10.	Pull overbed table across bed or chair.			
11.	Spread towel under patient's chin.			
12.	Plug in razor and place it on overbed table. **NOTE:** Be sure your hands are dry before plugging in razor.			
13.	Wash face thoroughly with soap and water to remove dirt and oil. Rinse with warm water.			
14.	Apply pre-shaving lotion to patient's face, if patient requests it or if it is part of his usual routine.			
15.	Turn on razor.			
16.	Start shaving from sideburns holding skin tightly and shaving in a circular motion over patient's face.			
17.	Using a circular motion, shave upward on neck, under chin, and around mouth.			
18.	Turn off razor and unplug when finished. **NOTE:** Be sure your hands are dry before unplugging razor.			
19.	Apply after-shave lotion if patient requests it or if it is part of his usual routine.			

Shaving With an Electric Razor Cont.		**Yes**	**No**	**Comments**
20.	Take blades out of razor and clean as directed. **NOTE**: Check with your supervisor. Patient may be able to tell you how to clean it.			
21.	Make patient comfortable. Place call light within reach.			
22.	Pull up side rails if appropriate and open curtain.			
23.	Put away razor and shaving lotions. **NOTE**: Be sure caps are screwed tightly on shaving lotions.			
24.	Place towel and washcloth with dirty linen.			
25.	Wash your hands.			
27.	Report anything unusual to your supervisor, including any sores on patient's face or neck, and nicks or cuts.			

Student's Signature/Date

Instructor's Signature/Date

Giving a Backrub

Unit Objectives

After completing this unit, you should be able to identify why backrubs are given and when they are given, as well as how to give one.

Specific Objectives

After completing this unit, you should be able to:

A. Identify purposes of the backrub.

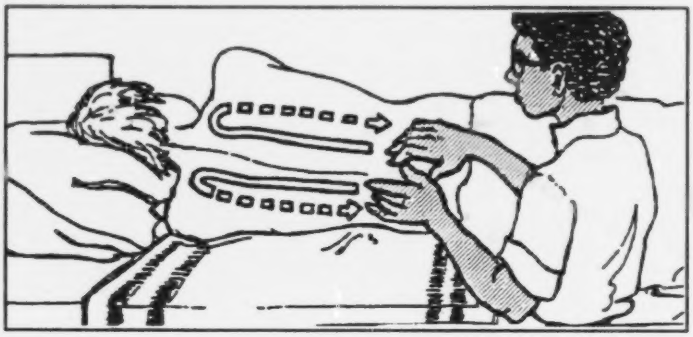
B. Identify when backrub is given.

C. Give a backrub according to steps of procedure.

Introduction

Backrubs are important to patients because they can soothe, calm, and comfort them. Backrubs also express to patients that their caregiver really does care.

In this unit, you will learn how to give a backrub.



A. Purposes of Backrubs

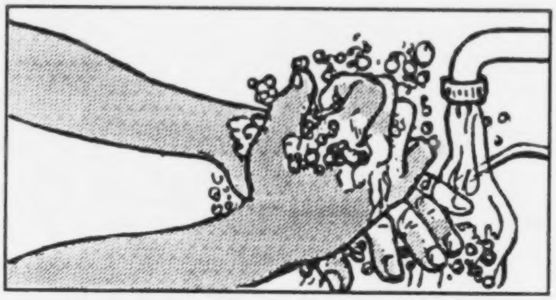
- Backrubs help to refresh and relax muscles and stimulate circulation. Patients need backrubs because their lack of movement does not stimulate circulation well enough.
- Backrubs relax muscles and, in general, relax the patient.
- Backrubs help relieve a patient's tension.

B. When to Give Backrubs

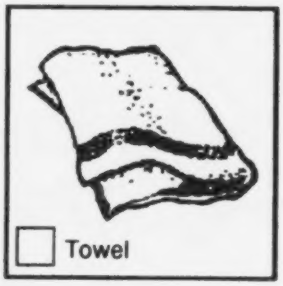
- Backrubs can be given after a bath or before bed.
- Backrubs can also be given when changing a patient's position, or when a patient is restless and needs relaxing.

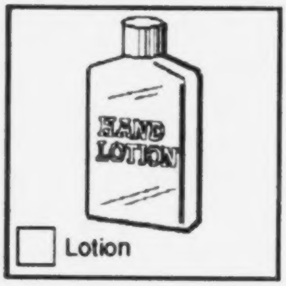
C. Steps of Procedure for Giving a Backrub

1. Wash your hands.



2. Assemble equipment.

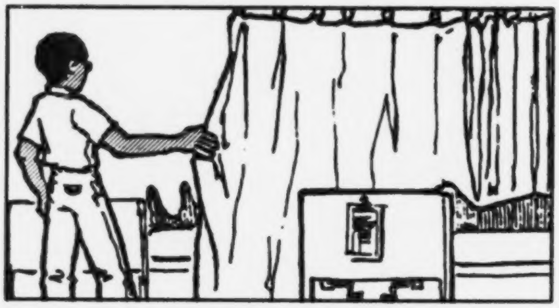




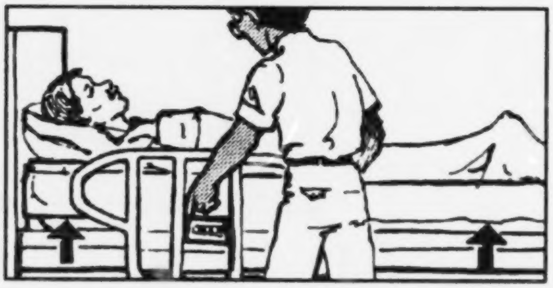
3. Identify and greet patient. Identify self.

4. Explain what you are going to do.

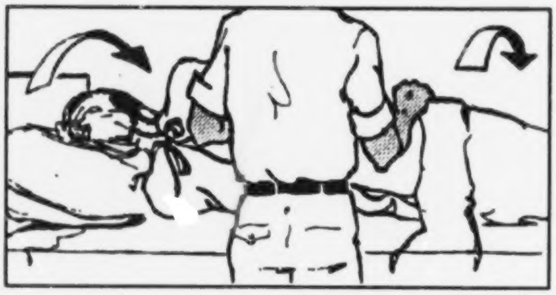
5. Provide privacy. Pull curtain around bed.



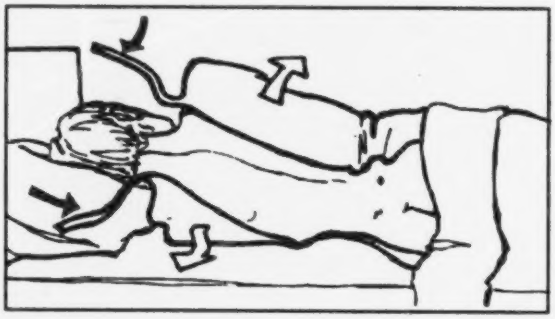
6. Lower side rail and raise bed.



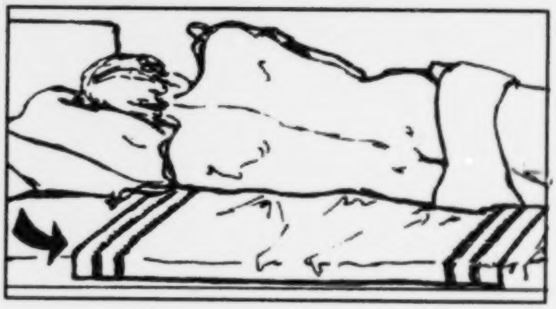
7. Position patient on the side of bed closest to you, then turn patient on his side or assist patient to lie on his abdomen.



8. Untie patient's gown. Open gown so back and buttocks are exposed.

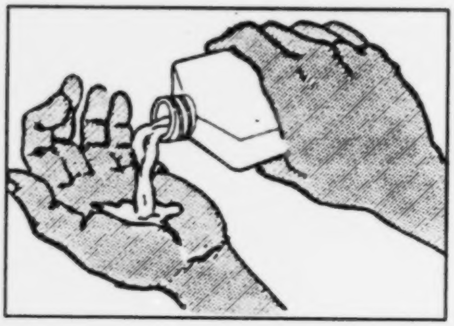


9. Put a bath towel lengthwise close to patient's back to protect bedding.

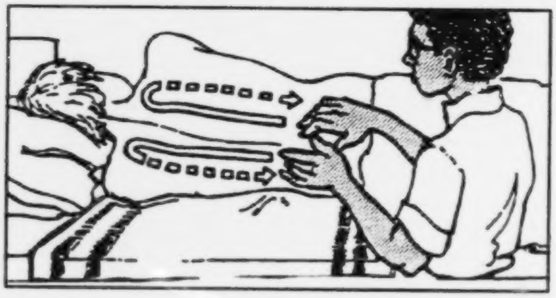


NOTE: If giving a bed bath or if back is soiled, wash, rinse, and dry back.

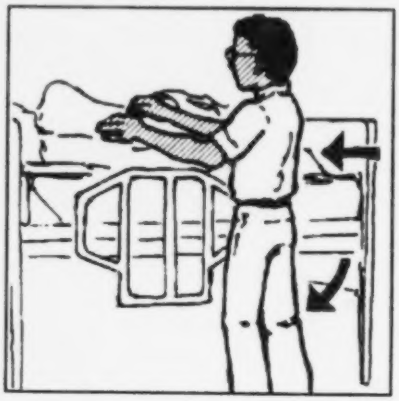
10. Pour small amount of lotion into your hand and rub your hands together to warm the lotion.



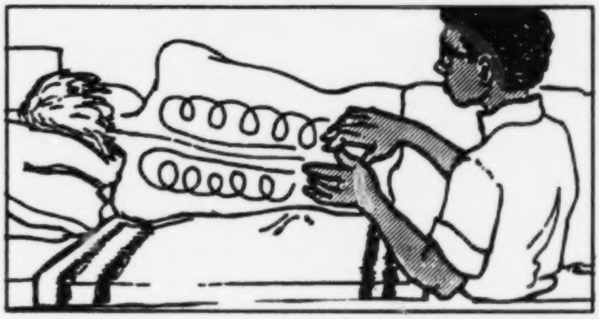
11. Apply lotion to the entire back using palms of hands. Use long soothing strokes from buttocks up the center, around the shoulders and back down the sides of the back and buttocks.



NOTE: Keep your knees slightly bent and your back straight.



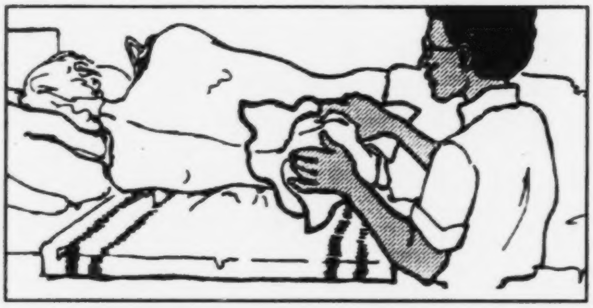
12. Rub in a circle when over a bony area like the shoulder blades or base of spine.



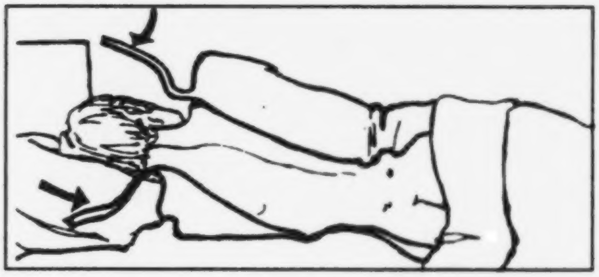
13. Rub the buttocks with a circular motion until all the lotion is absorbed into the skin.

CAUTION: The patient must be handled with extreme gentleness to prevent bruising and skin tears.

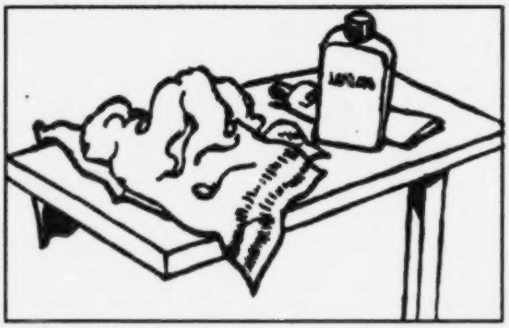
14. Gently dry patient's back of excess lotion by patting it with towel.



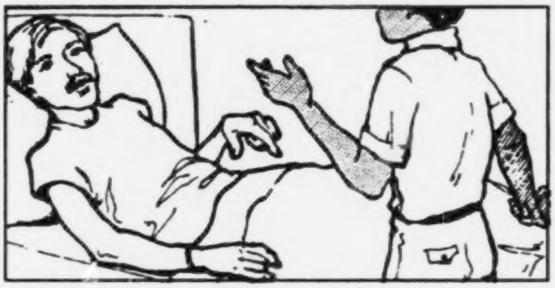
15. Close and retie gown.



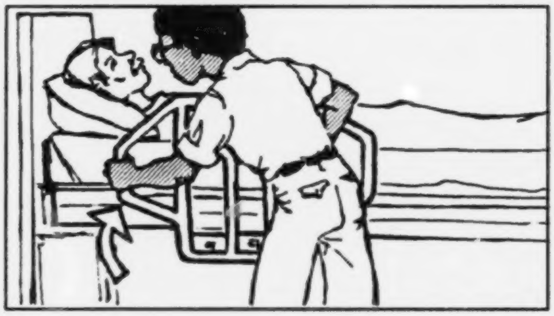
16. Place towel on overbed table.



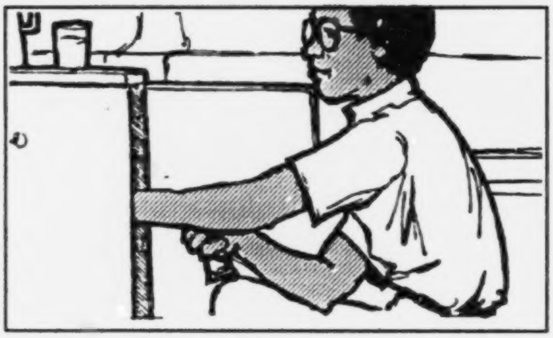
17. Help patient to get into a comfortable position.



18. Arrange covers neatly and pull up side rail if appropriate. Place call light within the patient's reach.

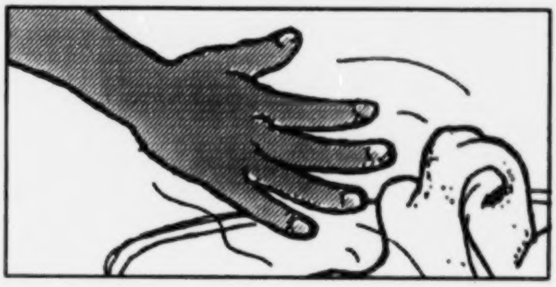


19. Return lotion to its proper place.

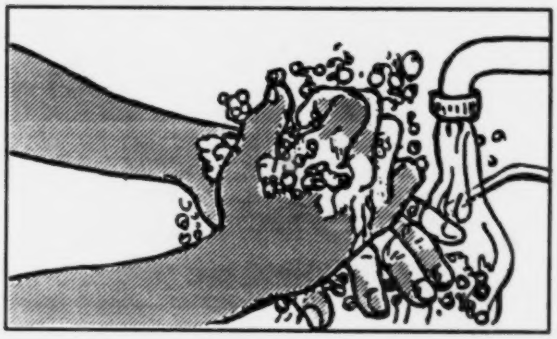


NOTE: Check to be sure lotion cap is screwed on tightly.

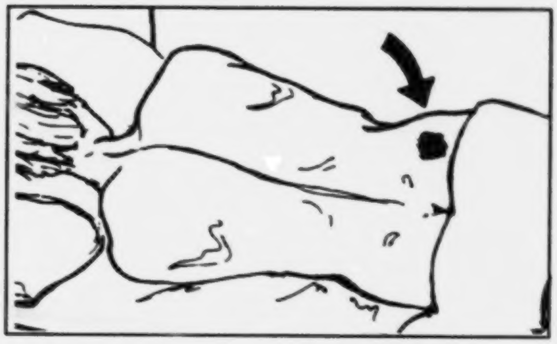
20. Put towel with dirty linen.



21. Wash your hands.



22. Report any reddened areas or sores on patient's back or buttocks.



CAUTION: Bedridden patients often get pressure sores. These usually start as a reddened area and then develop into a sore. It is important to treat them as soon as they begin. Always report any reddened areas or sores immediately.

Giving a Backrub

Written Evaluation

Circle the letter that corresponds to the best answer.

1. Rubbing a patient's back helps the patient to:

    a. Relax and refresh muscles.
    b. Become tense and angry.
    c. Decrease circulation.
    d. None of the above.

2. Backrubs are usually given:

    a. Before a bath.
    b. When a patient gets up in the morning.
    c. After a bath and before bed.
    d. Only when a patient is tense and angry.

Giving a Backrub

Evaluation

________________________has successfully completed the following steps of procedure.
(Student)

Giving a Backrub		Yes	No	Comments
1.	Wash hands.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Provide privacy. Pull curtain around bed.			
6.	Lower side rail and raise bed.			
7.	Position patient on the side of bed closest to you, then turn patient on his side or assist patient to lie on his abdomen.			
8.	Untie patient's gown. Open gown so back and buttocks are exposed.			
9.	Put a bath towel lengthwise close to patient's back to protect bedding. **NOTE:** If giving a bed bath or if back is soiled, wash, rinse, and dry back.			
10.	Pour small amount of lotion into your hand and rub your hands together to warm the lotion.			
11.	Apply lotion to the entire back with palms of hands. Use long soothing strokes from buttocks up the center, around the shoulders and back down the sides of the back and buttocks. **NOTE:** Keep your knees slightly bent and your back straight.			
12.	Rub in a circle when over a bony area like the shoulder blades or base of spine.			
13.	Rub the buttocks with a circular motion until the lotion is absorbed into the skin. **CAUTION:** The patient must be handled with extreme gentleness to prevent bruising and skin tears.			
14.	Gently dry patient's back of excess lotion by patting it with towel.			
15.	Close and retie gown.			
16.	Place towel on overbed table.			
17.	Help patient to get into a comfortable position.			
18.	Arrange covers neatly and pull up side rail if appropriate. Place call light within the patient's reach.			
19.	Return lotion to its proper place. **NOTE:** Check to be sure lotion cap is screwed on tightly.			

Giving a Backrub Cont.		Yes	No	Comments
20.	Put towel with dirty linen.			
21.	Wash your hands.			
22.	Report any reddened areas or sores on patient's back or buttocks. **CAUTION:** Bedridden patients often get pressure sores. These usually start as a reddened area and then develop into a sore. It is important to treat them as soon as they begin. Always report any reddened areas or sores immediately.			

Student's Signature/Date

Instructor's Signature/Date

Bedmaking

Unit Objective

After completing this unit, you should be able to make an unoccupied and an occupied bed.

Specific Objectives

After completing this unit, you should be able to:

A. Make an unoccupied bed according to steps of procedure.

B. Make an occupied bed according to steps of procedure.

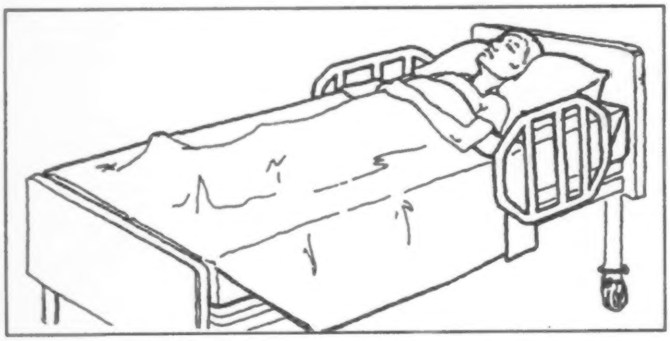
Introduction

Most patients in a health care facility spend more time in a bed than they are used to. The way a bed is made is very important to a patient's comfort and well being.

The bed should be as comfortable as possible. There should be no wrinkles in the sheets. Wrinkles are not only uncomfortable, but they also can cause pressure sores.

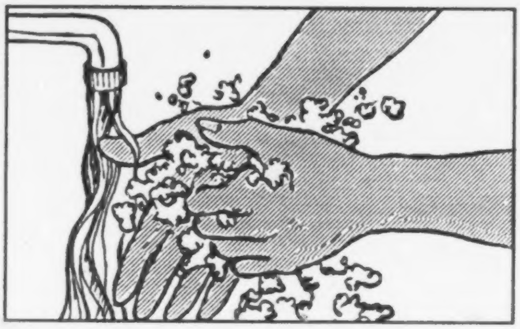
In this unit, you will learn how to make an unoccupied bed (a bed that is empty), and an occupied bed (a bed with a patient in it).

NOTE: Not all patient beds will require all pieces of bed linen listed in the procedures. Check with your supervisor.

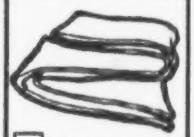


A. Steps of Procedure for Making an Unoccupied Bed

1. Wash your hands. Put on gloves.



2. Assemble equipment.



☐ Bottom sheet

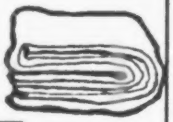
☐ Protective pad

☐ Top sheet

☐ Bedspread

☐ Linen bag

☐ Mattress pad



☐ Blanket

☐ Pillowcase

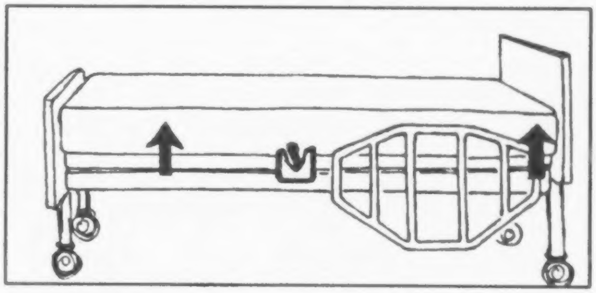
☐ Cotton Draw Sheet

3. Arrange necessary linens in order to be used: protective pad (if needed), pillowcase, bedspread, blanket, top sheet, cotton draw sheet, bottom sheet, and mattress pad or cover. Stack on a chair beside the bed.

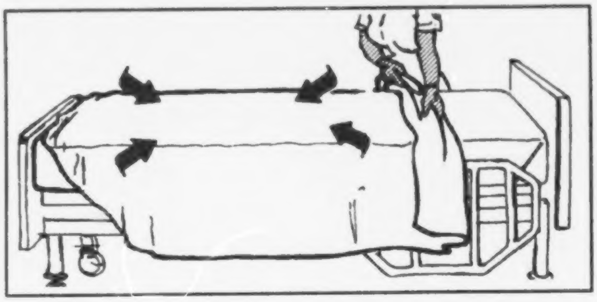
4. If patient is in the room, identify and greet patient. Identify self. Explain what you are going to do.

5. Raise bed to high position. Lower side rails.

NOTE: Bed should be in flat position.



6. Remove pillow and strip pillowcase being careful not to rub it against your body. Put it in bag for dirty linen.



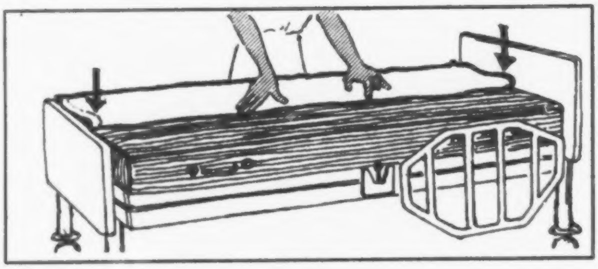
7. Loosen four corners of bed linen. Starting at a corner, roll linen toward center of bed. Roll all corners to center of bed. Place soiled linen in bag for dirty linen.

NOTE: Check linen for dentures, jewelry, glasses, etc. Also, be careful to not shake soiled linen or allow it to come in contact with your uniform as it will contaminate your clothes.

8. Wash and dry mattress, if soiled.

9. Remove gloves and dispose in appropriate container.

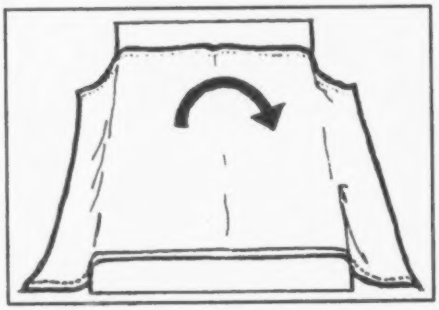
10. Wash hands.



11. Place mattress pad on bed and pull smooth.

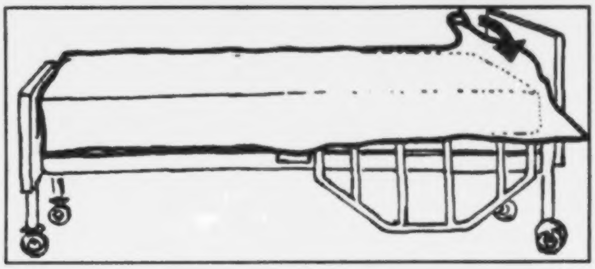
12. Place bottom sheet on bed, full length, with bottom hem at bottom edge of mattress. Be sure center fold is at center of mattress from head to foot.

NOTE: For fitted sheets, tuck in both sides of mattress pad and make sure all four corners are fitted securely under the mattress corners.

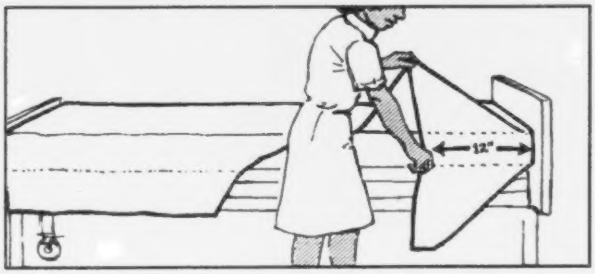


13. Open sheet from fold. Sheet should hang evenly over each side of the bed.

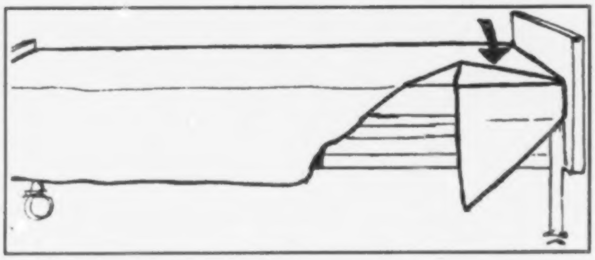
14. Tuck sheet under head of mattress.



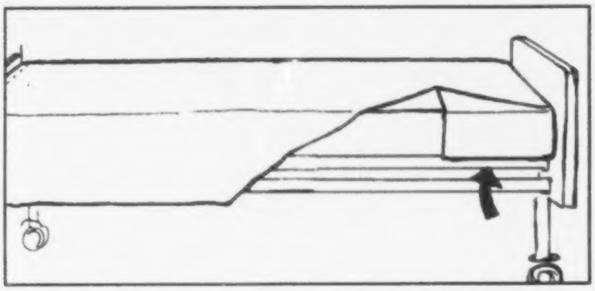
15. Pick up edge of sheet at twelve (12) inches from head of bed in order to miter corner.



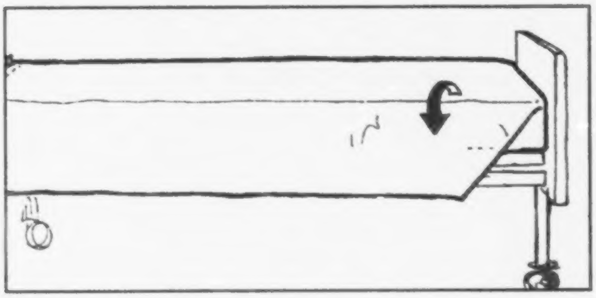
16. Place triangle on top of mattress.



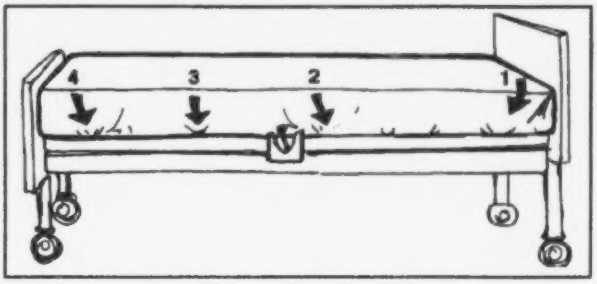
17. Tuck hanging portion under mattress.



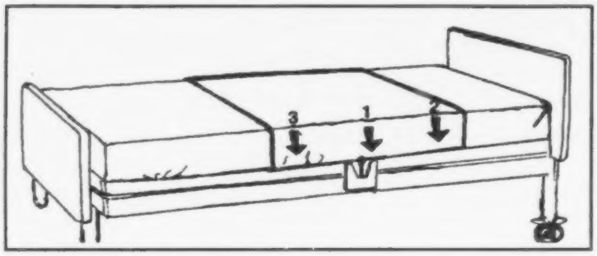
18. Bring triangle forward over side of mattress.



19. Tuck sheet under mattress down the entire side that you are making. Work from the head of the bed to the foot of the bed.

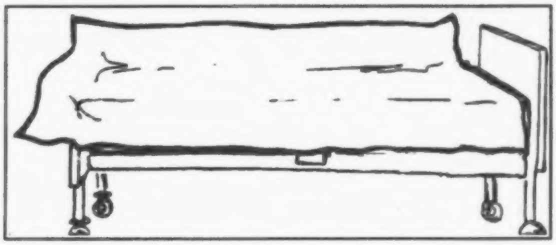


20. Folding cotton draw sheet in half, place on middle 1/3 of mattress. Unfold draw sheet and tuck in near side (side you are working on) only. Tuck in middle first, then top 1/3 and finally bottom 1/3.



21. Place top sheet, halved, full length of bed, with hem even with head end of mattress. Be sure center fold of sheet is at center of mattress from head to foot.

22. Unfold the top sheet and place it level with the top edge of the head of the mattress. Place it evenly over each side of bed.

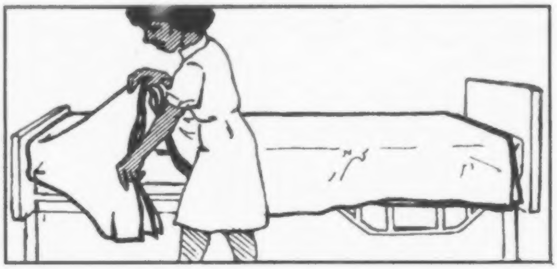


NOTE: Rough edge of hem should be facing up.

23. Place blanket over top sheet centered on bed and about eight (8) inches down from the edge of the top sheet.

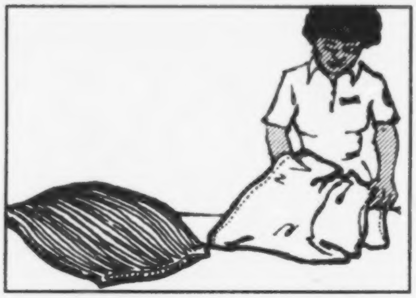
24. Place bedspread (centered) over top sheet and blanket, leave enough spread to cover a pillow at top edge.

25. Miter lower corner of sheet, blanket, and spread together on near side. (See steps 15-18.)

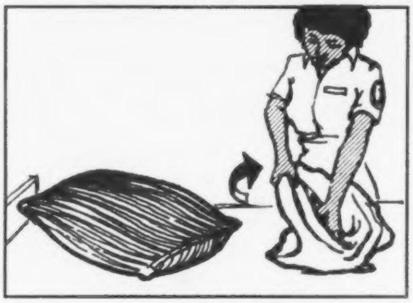


26. Place stripped pillow on bed.

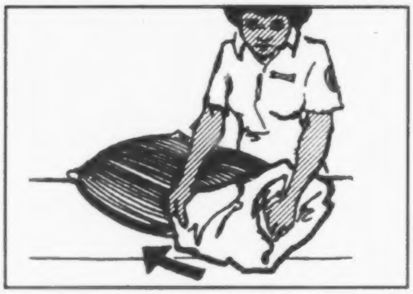
27. On outside of clean pillowcase, hold center of end seam.



28. With your hand outside of the pillowcase, turn pillowcase back over your hand.



29. Grasp pillow through the pillowcase at center of one end. Bring pillowcase down over pillow.



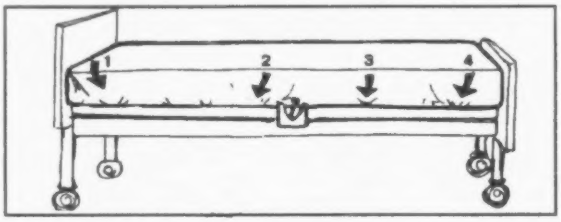
30. Place pillow on near half of bed with open end of case away from the doorway. Walk to far side of bed.

31. Fold back on bed each piece of linen.

32. Pull mattress pad smooth.

33. Pull bottom sheet tight and tuck under head of mattress.

34. Miter corner. (See steps 15-18). Then tuck in remainder of sheet, pulling sheet smooth as you work from the head of the bed to the foot of the bed.



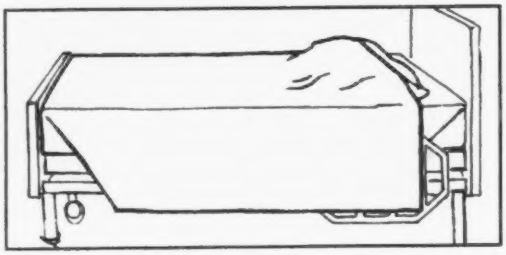
35. Tighten cotton draw sheet. Tuck in middle first, then top 1/3, and finally bottom 1/3.

36. Place protective pad (if using) on center of draw sheet.

37. Pull top sheet, blanket, and bedspread straight. Tuck under foot end of mattress.

38. Miter corner with top sheet, blanket, and bedspread. (See steps 15-18.)

39. Place pillow in center of head of bed. Pull bedspread over pillow.



40. Lower bed and recess bed cranks.

41. Raise side rails if appropriate. If patient is not in bed, raise side rail on the opposite side of entry.

42. Place call light within the patient's reach.

43. Take bag with dirty linen to appropriate container.

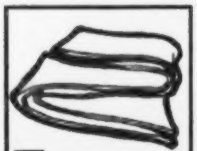
44. Wash your hands.

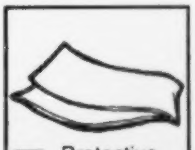
B. Steps of Procedure for Making an Occupied Bed

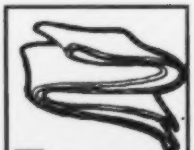
NOTE: Take extra care with patient when making an occupied bed.

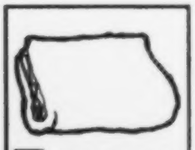
1. Wash your hands. Put on gloves.

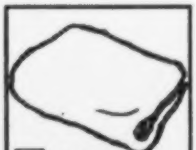
2. Assemble equipment.

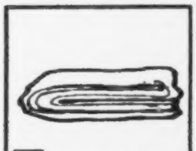

☐ Bottom sheet

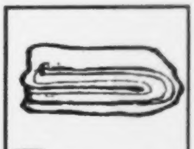

☐ Protective pad

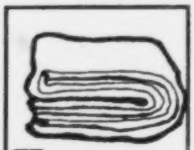

☐ Top sheet

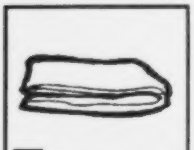

☐ Bedspread

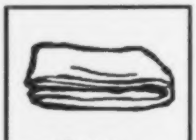

☐ Linen bag


☐ Bath blanket


☐ Mattress pad


☐ Blanket


☐ Pillowcase


☐ Cotton Drawsheet

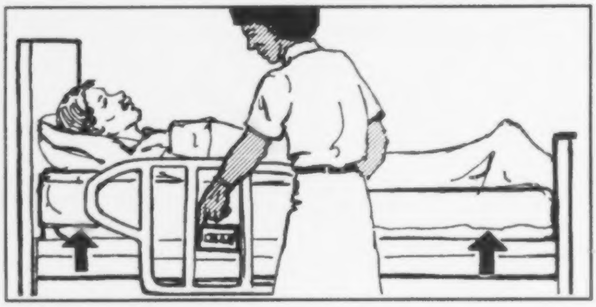
3. Arrange necessary linens in order to be used: pillowcase on bottom, then bedspread, blanket, top sheet, protective pad (if needed), cotton draw sheet, bottom sheet, and mattress pad or cover. Stack on a chair beside the bed.

4. Identify and greet patient. Identify self.

5. Explain what you are going to do.

6. Provide privacy. Pull curtain around bed.

7. Raise bed to comfortable working position. Lower side rail on side you will be working.



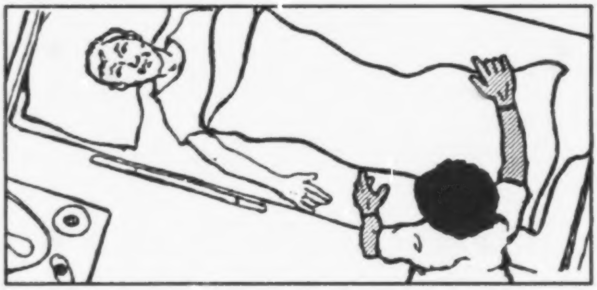
8. Lower back and knee rest until bed is flat, if patient's condition allows.

9. Loosen the top of bedding at foot of bed.

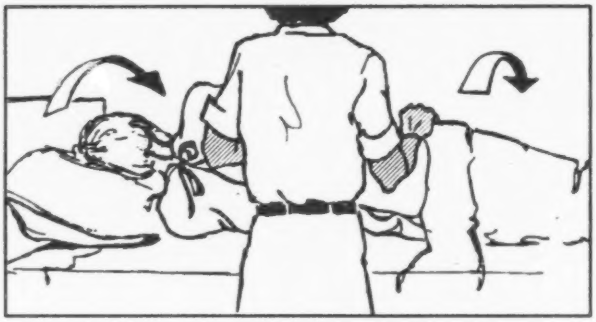
10. Remove bedspread. If it is unsoiled and to be reused, fold bedspread to foot of bed and remove it by grasping at the center. Place it on back of chair. If not being reused, place it in bag for dirty linen.

11. Remove blanket according to above procedure. Place on chair if to be reused, otherwise place in bag for dirty linen.

12. Place bath blanket over top sheet. Ask patient to hold blanket in place or tuck it under patient's shoulders. Remove top sheet and place it in bag for dirty linen.

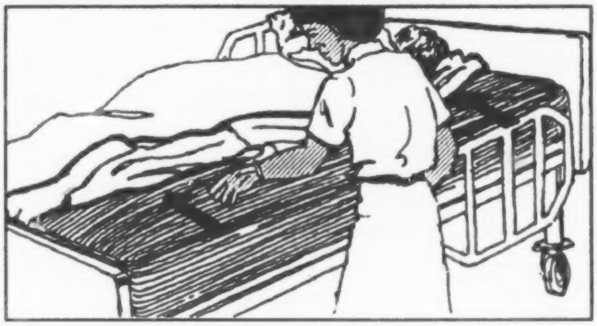


13. Keep pillow under patient's head and turn patient to side of bed you are not making.



14. Free bottom linen and roll each piece to the patient's back.

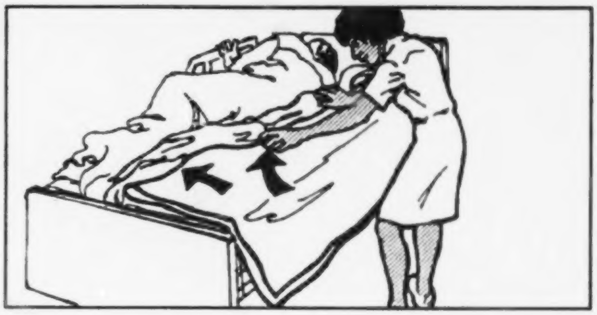
NOTE: If mattress is soiled, clean and dry it.



15. Remove gloves and dispose in appropriate container.

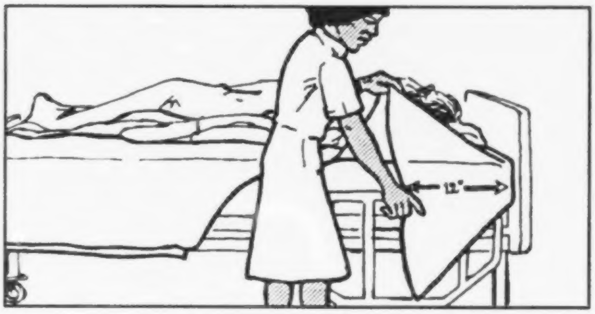
16. Wash hands.

17. Place mattress pad on bed lengthwise with fold in the center. Straighten pad.

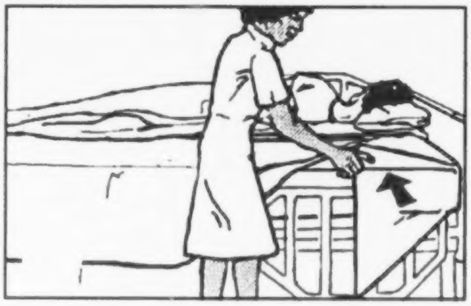


18. Place bottom sheet lengthwise with fold in center and lower edge of sheet even with foot of mattress.

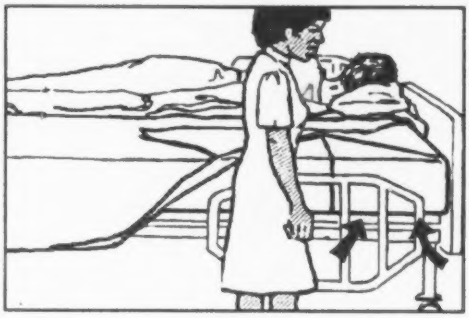
19. Tuck sheet under head of mattress. Pick up edge of sheet at twelve (12) inches from head of bed in order to miter corner.



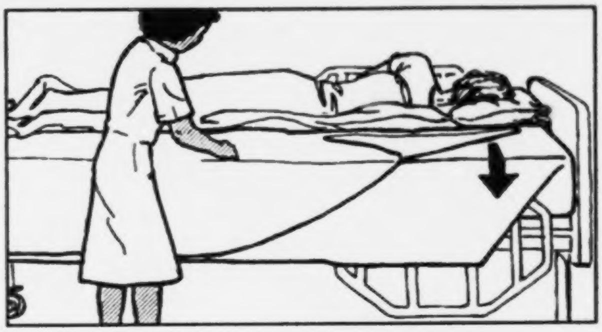
20. Place triangle on top of mattress.



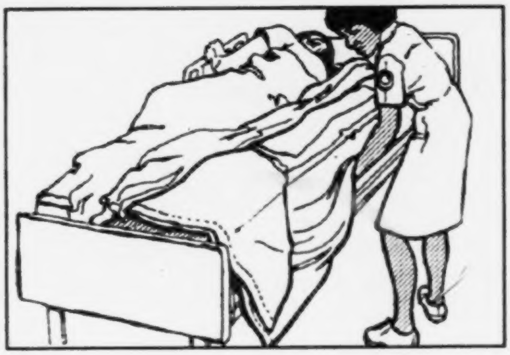
21. Tuck hanging portion under mattress.



22. Bring triangle forward over side of mattress.

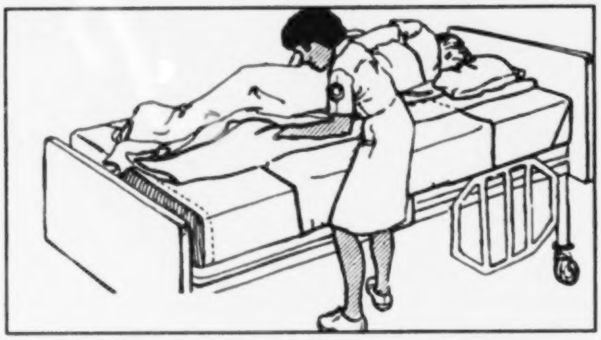


23. Tuck sheet under side of mattress working from the head of the bed down to the foot of the bed.



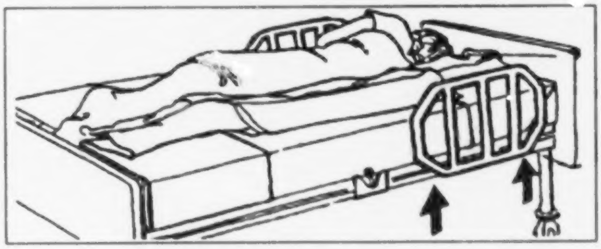
24. Fanfold top half of bottom sheet close to patient's back.

25. Place cotton draw sheet on middle 1/3 of mattress; fanfold 1/2 to patient's back and tuck in near side only.



26. Center protective pad over cotton draw sheet. Fanfold one-half to patient's back and tuck other end under mattress.

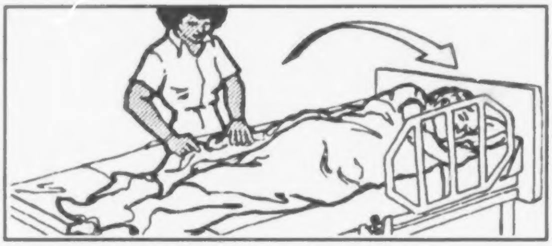
27. Raise side rail if appropriate. Assist patient in turning and moving to side of bed you just made.



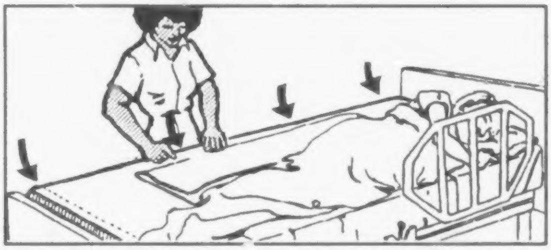
28. Move and keep pillow under patient's head.

29. Put on gloves. Go to opposite side of bed. Lower side rail.

30. Pull through all bottom linen. Remove and discard soiled linen in linen bag. If mattress is soiled, clean and dry it. Remove gloves.



31. Pull clean mattress pad toward edge of bed. Straighten pad.

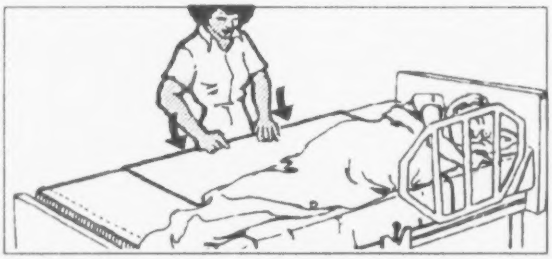


32. Pull clean bottom sheet toward the edge of bed. Tuck it under the mattress at the head of the bed and make a mitered corner. (See steps 19-22.)

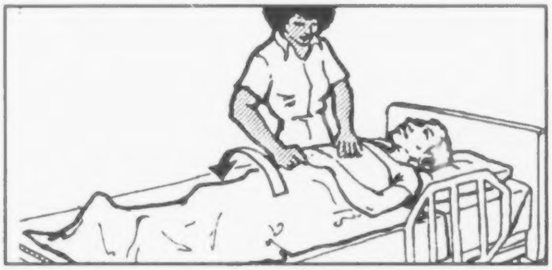
33. Tuck sheet under mattress.

34. Pull protective pad and cotton draw sheet across bed and tighten. Tuck cotton draw sheet under the mattress.

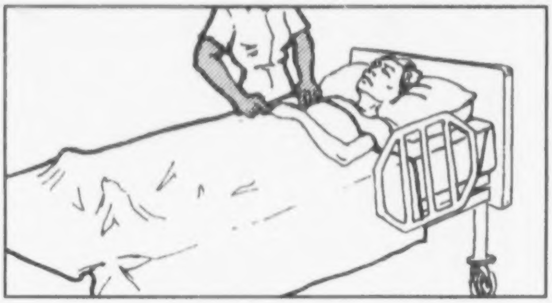
NOTE: Make sure there are no wrinkles.



35. Assist patient to center of bed.



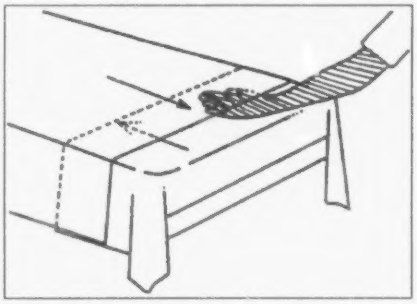
36. Place top sheet over bath blanket. Ask patient to hold it or tuck under the patient's shoulders.



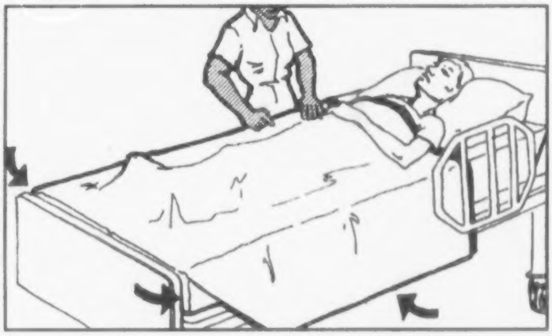
37. Remove bath blanket and place in linen container.

38. If blanket is used, place it over top sheet. Place bedspread over blanket even with top sheet.

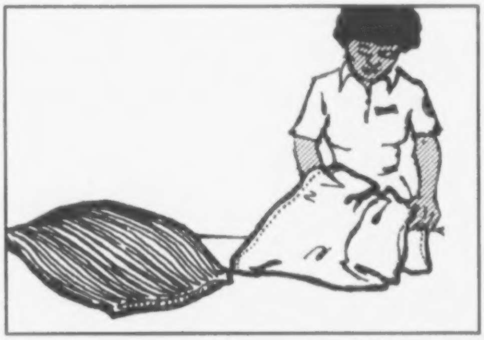
39. Make tuck in top linen at foot of bed. Make toe pleat by folding over two (2) inches where feet are.



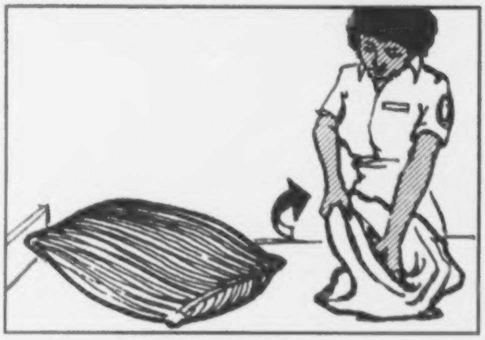
40. Tuck sheet, blanket, and bedspread at foot of bed under mattress and miter corners on each side. (See steps 19-22.)



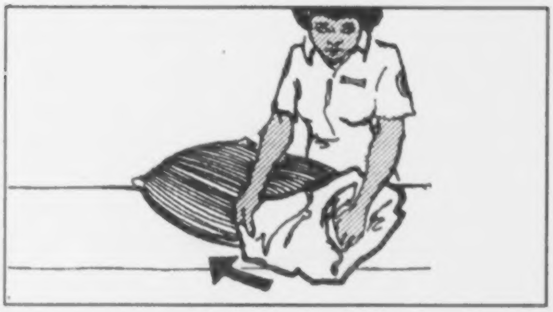
41. Gently take pillow from under patient's head. Remove pillowcase, being careful not to rub it against your body. Place pillow on bed. Put used pillowcase with dirty linen.



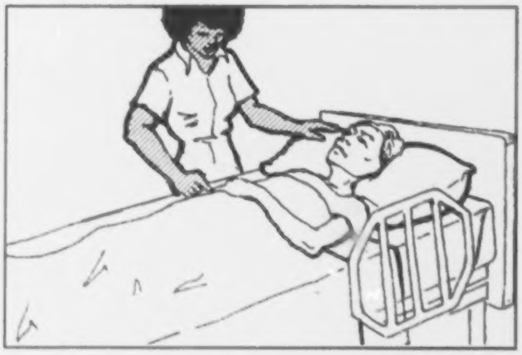
42. Hold clean pillowcase at center of end seam.



43. With your hand outside of the pillowcase, turn pillowcase back over your hand.



44. Grasp pillow through the pillowcase at center of one end. Bring pillowcase down over pillow.



45. Gently put pillow back under patient's head.

46. Lower bed and recess bed cranks.

47. Raise side rails if appropriate.

48. Place call light within reach.

49. Take bag with dirty linen to appropriate container.

50. Wash your hands.

Bedmaking

Written Evaluation

Circle the letter that corresponds to the best answer.

1. A bed which has been made up with a patient in it is called:

   a. A surgical bed.
   b. An occupied bed.
   c. A patient bed.
   d. A full bed.

2. When making a bed, there should be no wrinkles in the bed because:

   a. Wrinkles are hard to keep clean.
   b. Wrinkles can cause pressure sores.
   c. Wrinkles can keep the patient awake.
   d. Wrinkles look bad.

3. A bed which is made up without a patient in it is called:

   a. An unoccupied bed.
   b. An open bed.
   c. An occupied bed.
   d. An empty bed.

Bedmaking
Evaluation

_____________________has successfully performed the following steps of procedure.
(Student)

Making an Unoccupied Bed		Yes	No	Comments
1.	Wash your hands. Put on gloves.			
2.	Assemble equipment.			
3.	Arrange necessary linens in order to be used: protective pad (if needed), pillowcase, bedspread, blanket, top sheet, cotton draw sheet, bottom sheet, and mattress pad or cover. Stack on a chair beside the bed.			
4.	If patient is in the room, identify and greet patient. Identify self. Explain what you are going to do.			
5.	Raise bed to high position. Lower side rails. **NOTE:** Bed should be in flat position.			
6.	Remove pillow and strip pillowcase being careful not to rub it against your body. Put it in bag for dirty linen.			
7.	Loosen four corners of bed linen. Starting at the corner, roll linen toward center of bed. Roll all corners to center of bed. Place soiled linen in bag for dirty linen. **NOTE:** Check linen for dentures, jewelry, glasses, etc. Also, be careful to not shake soiled linen or allow it to come in contact with your uniform as it will contaminate your clothes.			
8.	Wash and dry mattress, if soiled.			
9.	Remove gloves and dispose in appropriate container.			
10.	Wash hands.			
11.	Place mattress pad on bed and pull smooth.			
12.	Place bottom sheet on bed, full length, with bottom hem at bottom edge of mattress. Be sure center fold is at center of mattress from head to foot. **NOTE:** For fitted sheets, tuck in both sides of mattress pad and make sure all four corners are fitted securely under the mattress corners.			
13.	Open sheet from fold. Sheet should hang evenly over each side of bed.			
14.	Tuck sheet under head of mattress.			
15.	Pick up edge of sheet at twelve (12) inches from head of bed in order to miter corner.			
16.	Place triangle on top of mattress.			
17.	Tuck hanging portion under mattress.			
18.	Bring triangle forward over side of mattress.			
19.	Tuck sheet under mattress down the entire side that you are making. Work from the head of the bed down to the foot of the bed.			

Making an Unoccupied Bed Cont.		Yes	No	Comments
20.	Folding cotton draw sheet in half, place on middle 1/3 of mattress. Unfold draw sheet and tuck in near side (side you are working on) only. Tuck in middle first, then top 1/3, and finally bottom 1/3.			
21.	Place top sheet, halved, full length of bed, with hem even with head end of mattress. Be sure center fold of sheet is at center of mattress from head to foot.			
22.	Unfold the top sheet and place it level with the top edge of the head of the mattress. Place it evenly over each side of bed. **NOTE:** Rough edge of hem should be facing up.			
23.	Place blanket over top sheet centered on bed and about eight (8) inches down from the edge of the top sheet.			
24.	Place bedspread (centered) over top sheet, leave enough spread to cover a pillow at top edge.			
25.	Miter lower corner of sheet, blanket, and spread together on near side. (See steps 15-18.)			
26.	Place stripped pillow on bed.			
27.	On outside of pillowcase hold center of end seam.			
28.	With your hand outside of the pillowcase, turn pillowcase back over your hand.			
29.	Grasp pillow through the pillowcase at center of one end. Bring pillowcase down over pillow.			
30.	Place pillow on near half of bed with open end of case away from the doorway. Walk to far side of bed.			
31.	Fold back on bed each piece of linen.			
32.	Pull mattress pad smooth.			
33.	Pull bottom sheet tight and tuck under head of mattress.			
34.	Miter corner. (See steps 15-18). Then tuck in remainder of sheet, pulling sheet smooth as you work from the head of the bed to the foot of the bed.			
35.	Tighten cotton draw sheet. Tuck in middle first, then top 1/3, and finally bottom 1/3.			
36.	Place protective pad (if using) on center of draw sheet.			
37.	Pull top sheet, blanket, and bedspread straight. Tuck under foot end of mattress.			
38.	Miter corner with top sheet, blanket, and bedspread. (See steps 15-18.)			
39.	Place pillow in center of head of bed. Pull bedspread over pillow.			
40.	Lower bed and recess bed cranks.			
41.	Raise side rails if appropriate. If patient is not in bed, raise side rail on the opposite side of entry.			
42.	Place call light within the patient's reach.			
43.	Take bag with dirty linen to appropriate container.			
44.	Wash your hands.			

Making an Occupied Bed		Yes	No	Comments
NOTE: Take extra care with patient when making an occupied bed.				
1.	Wash your hands. Put on gloves.			
2.	Assemble equipment.			
3.	Arrange necessary linens in order to be used: pillowcase on bottom, then bedspread, blanket, top sheet, protective pad (if needed), cotton draw sheet, plastic or rubber draw sheet, bottom sheet, and mattress pad or cover. Stack on a chair beside the bed.			
4.	Identify and greet patient. Identify self.			
5.	Explain what you are going to do.			
6.	Provide privacy. Pull curtain around bed.			
7.	Raise bed to comfortable working position. Lower side rail on side you will be working.			
8.	Lower back and knee rest until bed is flat, if patient's condition allows.			
9.	Loosen the top of bedding at foot of bed.			
10.	Remove bedspread. If unsoiled and to be reused, fold bedspread to foot of bed and remove it by grasping at the center. Place it on back of chair. If not being reused, place it in bag for dirty linen.			
11.	Remove blanket according to above procedure. Place on chair if to be reused, otherwise place it in bag for dirty linen.			
12.	Place bath blanket over top sheet. Ask patient to hold blanket in place or tuck it under patient's shoulders. Remove top sheet and place it in bag for dirty linen.			
13.	Keep pillow under patient's head and turn patient to side of bed you are not making.			
14.	Free bottom linen and roll each piece to the patient's back. **NOTE:** If mattress is soiled, clean and dry it.			
15.	Remove gloves and dispose in appropriate container.			
16.	Wash hands.			
17.	Place mattress pad on bed lengthwise with fold in the center. Straighten pad.			
18.	Place bottom sheet lengthwise with fold in center and lower edge of sheet even with foot of mattress.			
19.	Tuck sheet under head of mattress. Pick up edge of sheet at twelve (12) inches from head of bed in order to miter corner.			
20.	Place triangle on top of mattress.			
21.	Tuck hanging portion under mattress.			
22.	Bring triangle forward over side of mattress.			

Making an Occupied Bed Cont.		Yes	No	Comments
23.	Tuck sheet under side of mattress working from the head of the bed down to the foot of the bed.			
24.	Fanfold top half of bottom sheet close to patient's back.			
25.	Place cotton draw sheet on middle 1/3 of mattress; fanfold 1/2 to patient's back and tuck in near side only.			
26.	Center protective pad over cotton draw sheet. Fanfold one-half to patient's back and tuck other end under mattress.			
27.	Raise side rail if appropriate. Assist patient in turning and moving to side of bed you just made.			
28.	Move and keep pillow under patient's head.			
29.	Put on gloves. Go to opposite side of bed. Lower side rail.			
30.	Pull through all bottom linen. Remove and discard soiled linen in linen bag. If mattress is soiled, clean and dry it. Remove gloves.			
31.	Pull clean mattress pad toward edge. Straighten pad.			
32.	Pull clean bottom sheet toward the edge of bed. Tuck it under the mattress at the head of the bed and make a mitered corner. (See steps 19-22.)			
33.	Tuck sheet under mattress.			
34.	Pull protective pad and cotton draw sheet across bed and tighten. Tuck cotton draw sheet under the mattress. **NOTE:** Make sure there are no wrinkles.			
35.	Assist patient to center of bed.			
36.	Place top sheet over bath blanket. Ask patient to hold it or tuck under the patient's shoulders.			
37.	Remove bath blanket and place in linen container.			
38.	If blanket is used, place it over top sheet. Place bedspread over blanket even with top sheet.			
39.	Make tuck in top linen at foot of bed. Make toe pleat by folding over two (2) inches where feet are.			
40.	Tuck sheet, blanket, and bedspread at foot of bed under mattress and miter corners on each side. (See steps 19-22.)			
41.	Gently take pillow from under patient's head. Remove pillowcase, being careful not to rub it against your body. Place pillow on bed. Put used pillowcase with dirty linen.			
42.	Hold clean pillowcase at center of end seam.			
43.	With your hand outside of the pillowcase, turn pillowcase back over your hand.			
44.	Grasp pillow through the pillowcase at center of one end. Bring pillowcase down over pillow.			
45.	Gently put pillow back under patient's head.			

Making an Occupied Bed Cont.		Yes	No	Comments
46.	Lower bed and recess bed cranks.			
47.	Pull up side rails if appropriate.			
48.	Place call light within reach.			
49.	Take bag with dirty linen to appropriate container.			
50.	Wash your hands.			

Student's Signature/Date

Instructor's Signature/Date

Body Mechanics

Unit Objective

After completing this unit, you should be able to move and lift patients and objects using good body mechanics.

Specific Objectives

After completing this unit, you should be able to:

A. Identify rules of good body mechanics.

B. Assist/raise patient's head and shoulders according to steps of procedure.

C. Assist/move patient to head of bed according to steps of procedure.

D. Move helpless patient to head of bed according to steps of procedure.

E. Move patient to one side of the bed according to steps of procedure.

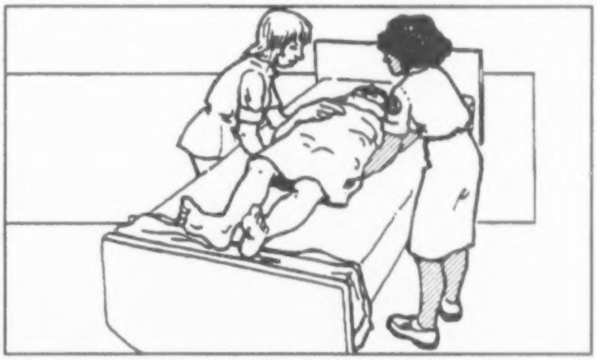
F. Turn patient on side according to steps of procedure.

G. Turn patient to prone position according to steps of procedure.

Introduction

Many health service tasks require lifting and moving patients. When lifting or moving, it is important to use good "body mechanics." Body mechanics is a term that refers to certain ways of standing and moving your body. Good body mechanics make the best use of your strength and help you to avoid injury and fatigue so that you feel better at the end of the day.

In this unit, you will learn how to lift and move patients and objects using good body mechanics.



A. Rules of Good Body Mechanics

Use as many muscles as possible. For example, use both hands instead of one hand.

Get close to whatever you are moving or lifting.

Keep your weight equal on both feet and keep your knees slightly bent.

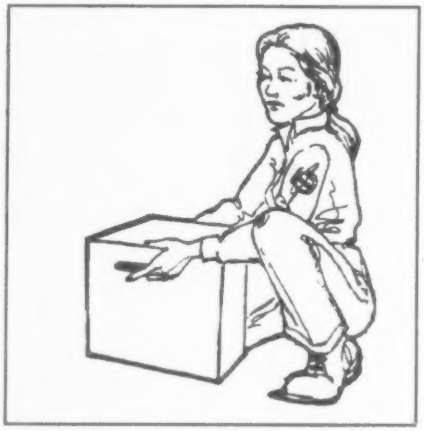
Keep your feet about 12 inches apart to give you support and good balance.

Get help if the load seems too heavy.

Lift smoothly to avoid strain. When working with another person, lift together. For example, count "one, two, three" and lift together on three.

When lifting an object it is important to:

- Squat or kneel rather than bend over.
- Keep your back straight.
- Grip object firmly and close to your body.
- Lift up with your leg muscles.



When lifting and/or moving a patient it is important to:

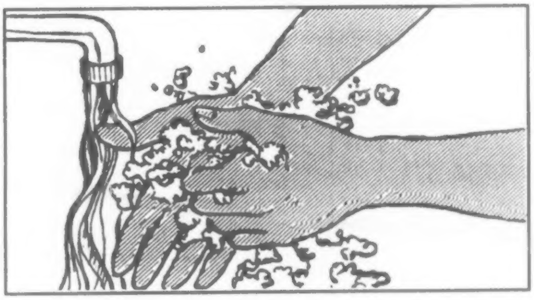
- Determine if you need help beforehand. Get help if the patient has special equipment such as IVs or oxygen, or if patient cannot assist.
- Give the most support to the heaviest part of the patient's body.

- Position chair against a solid surface such as a wall or a piece of furniture if moving patient to a chair. This will prevent the chair from sliding.
- Wear gloves if there is a possibility of contact with wet linen, blood, or body fluid.
- Use a turning sheet for turning. The turning sheet is placed from above the patient's shoulders to below patient's hips. A turning sheet can be used to turn or move patients.
- Always make certain that the patient's body is in good alignment and check condition of the skin.
- Hold the patient close to your body for the best support.

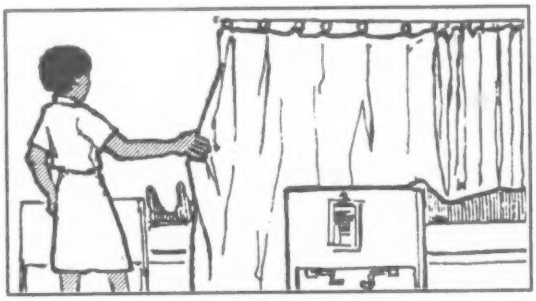
B. Steps of Procedure for Assisting/Raising Patient's Head and Shoulders

1. Wash your hands.

NOTE: Wear gloves if there is a possibility of contact with wet linen, blood, or body fluids.



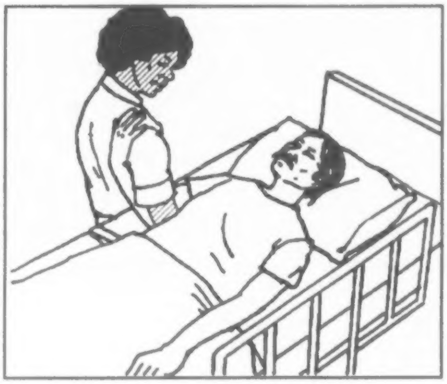
2. Identify and greet patient. Identify self.
3. Explain what you are going to do.
4. Provide privacy. Pull curtain around bed.
5. Raise bed to a comfortable working height. Lock wheels on bed. Lower backrest. Lower side rail on side at which you are working.



6. If the patient has any tubing coming from his body and it is pinned to the bedding, unfasten and arrange it so the tubing will move freely with the patient.

7. Face the head of the bed with your knees shoulder width apart. Bend your knees. Keep your back straight.

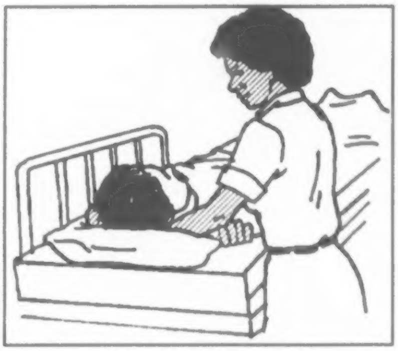
8. Instruct the patient to put his arm under your arm closest to him. Patient should put his arm behind your shoulder, with his hand over the top of your shoulder.



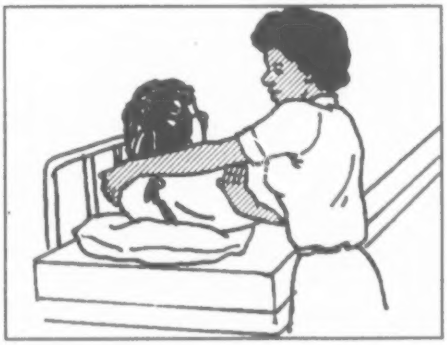
NOTE: If you are standing at his right side, patient's right hand will be on your right shoulder. If you are on his left, patient's left hand would be on your left shoulder.

9. Put your arm under the patient's arm with your hand on his shoulder. Thus, you will lock arms with the patient.

10. Put your other arm around the patient's shoulders.



11. Count one, two, three. On three, help the patient pull himself up as you support him and he raises his head and shoulders.



12. Turn or replace the pillow with the hand you have around the patient's neck and shoulder.

13. Help the patient gently lie down again, supporting him with your locked arm and the arm around his neck and shoulder.

14. Make the patient comfortable. Place call light within reach.

15. Raise side rails if appropriate. Lower the bed to a position of safety for the patient.

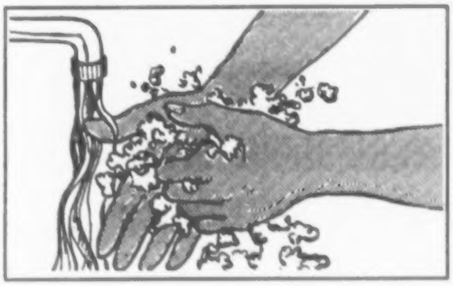
16. Open curtain.

17. Wash your hands.

C. Steps of Procedure for Moving/Assisting Patient to Head of Bed

1. Wash your hands.

NOTE: Wear gloves if there is a possibility of contact with wet linen, blood, or body fluids.

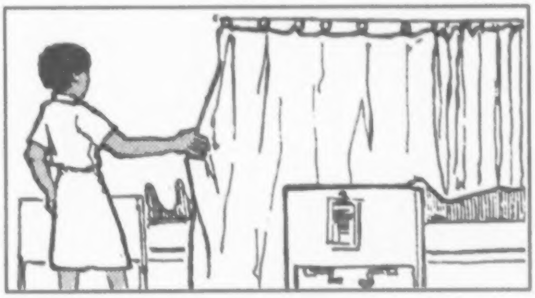


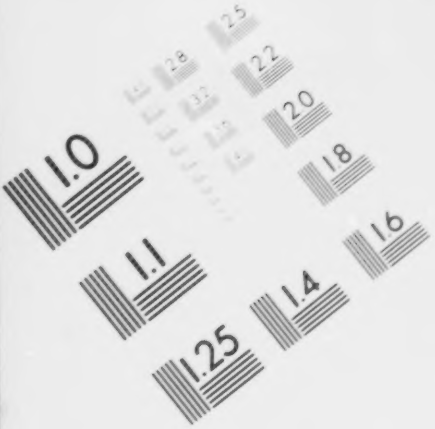
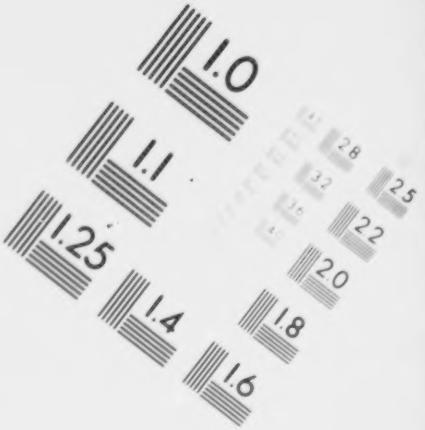
2. Identify and greet patient. Identify self.

3. Explain what you are going to do.

4. Provide privacy. Pull curtain around bed.

5. Raise bed to a comfortable working height. Lock wheels on bed. Lower backrest. Lower side rail on side at which you are working.



AIIM

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Centimeter
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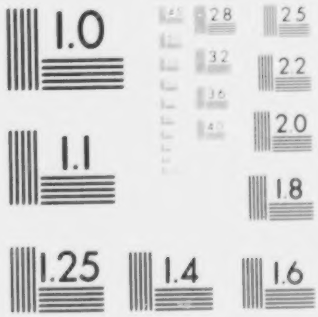
Inches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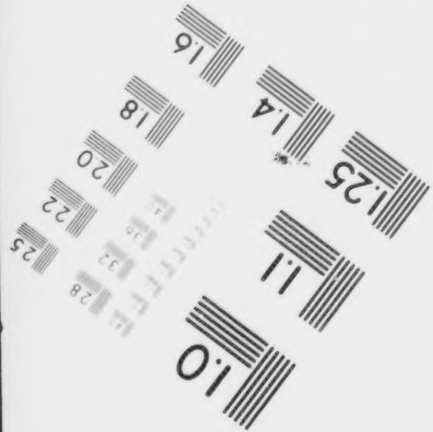
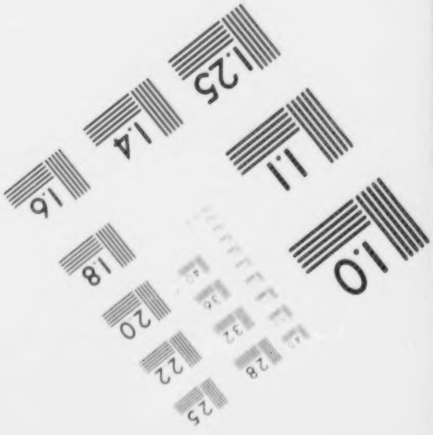

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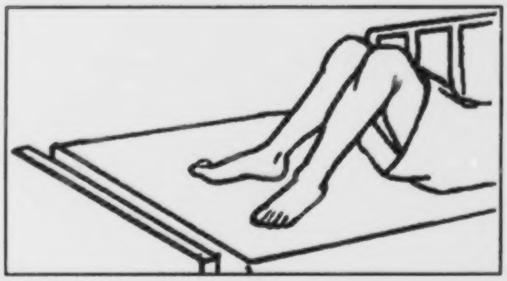
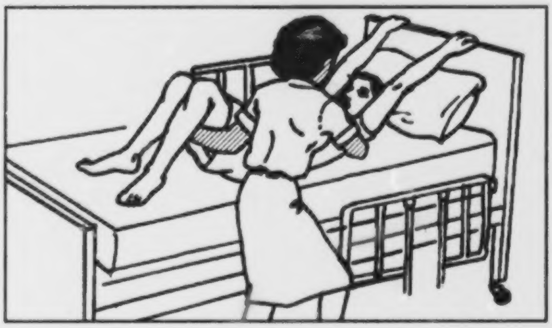
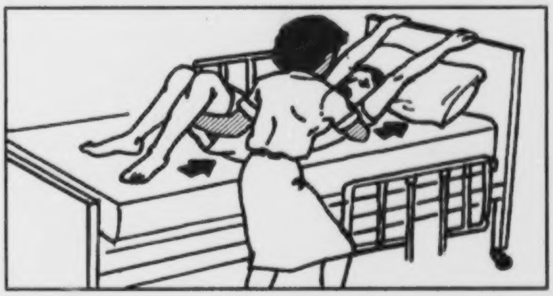
6. If the patient has any tubing coming from his body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the patient.
7. Move pillow to headboard so patient does not hit his head when moving up. Fanfold top covers to foot of bed.
8. Help patient bend his knees and press feet firmly against the mattress.



9. If patient is able, have him grasp head of bed, otherwise cross his arms over chest.



10. Slide one arm under patient's shoulders and the other under the thighs.
11. Stand facing head of the bed with your feet 18 inches apart. One foot should be slightly ahead of the other.
12. On the count of three, have the patient push with his feet and you shift your weight from your back leg to your front leg as you slide the patient up in the bed.



13. Replace pillows.
14. Adjust backrest for comfort.

15. Lower bed to a position of safety. Raise side rails if appropriate.

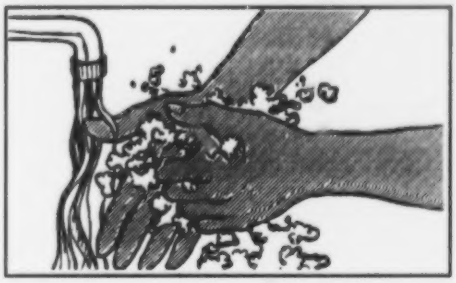
16. Make the patient comfortable. Place call signal within reach.

17. Fasten tubing if unpinned while moving patient. Adjust bedding.

18. Wash your hands.

D. Steps of Procedure for Moving Helpless Patient to Head of Bed

1. Wash hands.



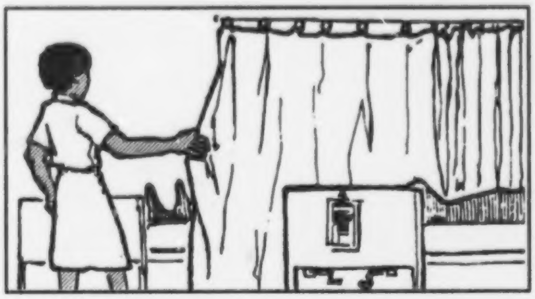
NOTE: Wear gloves if there is a possibility of contact with wet linen, blood, or body fluids.

2. Ask another nurse assistant to work with you.

3. Identify and greet patient. Identify self and other nurse assistant. Explain what you are going to do.

4. Provide privacy. Pull curtain around bed.

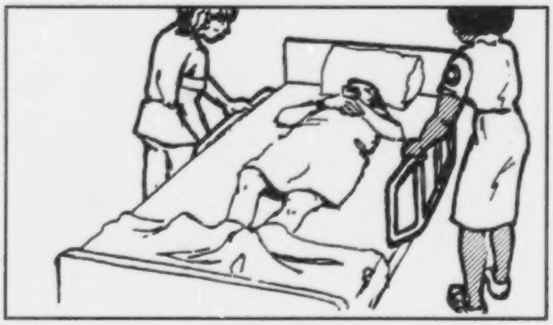
5. Raise bed to a comfortable working height. Lock wheels on bed. Lower backrest. Lower side rail on side at which you are working.



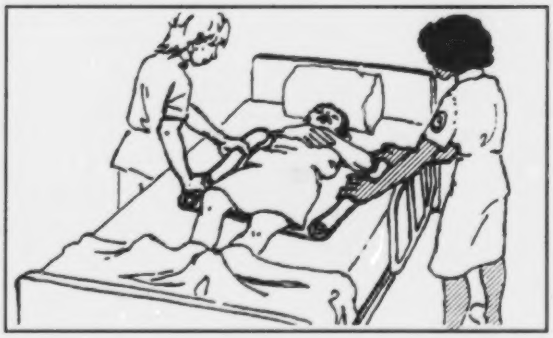
6. If the patient has any tubing coming from his body and it is pinned to the bedding, unfasten and arrange the tubing so that it will move freely with the patient.

7. Move pillow to headboard so patient does not hit his head when moving up. Fanfold top sheet to foot of bed. Make sure gown is covering patient so patient is not exposed.

8. Nurse assistants should stand on opposite sides of the bed.

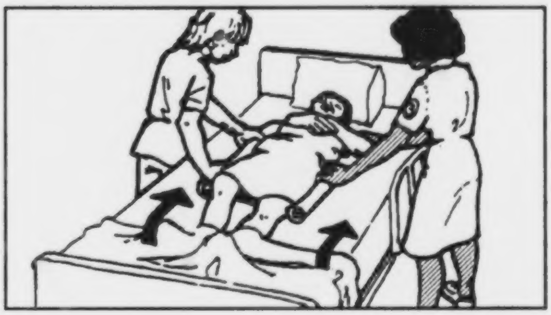


9. Position a draw sheet/folded regular sheet under shoulders and hip area. Each nurse assistant should roll edges of sheet toward patient's body and grasp rolled sheet at the patient's shoulders and at the mid-hip area.



10. Your feet should be pointed in the direction you are moving the patient. Bend knees, keep back straight.

11. On the count of three, each nurse assistant lifts the patient up off the surface of the bed and toward the head of the bed while shifting weight from back foot to front foot.



12. Replace pillow.

13. Adjust backrest for comfort.

14. Lower bed to a position of safety. Raise side rails if appropriate.

15. Make the patient comfortable. Place call signal within reach.

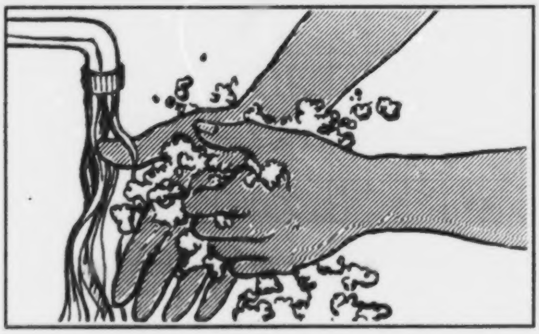
16. Fasten tubing if unpinned while moving patient. Adjust bedding.

17. Wash your hands.

E. Steps of Procedure for Moving Patient to Side of the Bed

1. Wash your hands.

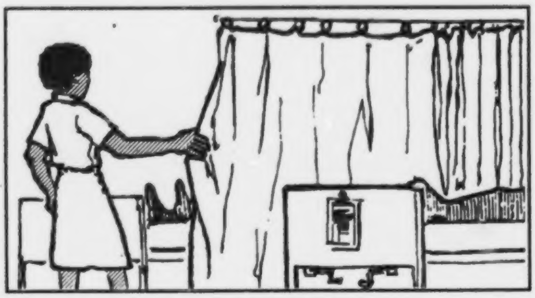
NOTE: Wear gloves if there is a possibility of contact with wet linen, blood, or body fluids.



2. Identify and greet patient. Identify self.

3. Explain what you are going to do.

4. Provide privacy. Pull curtain around bed.



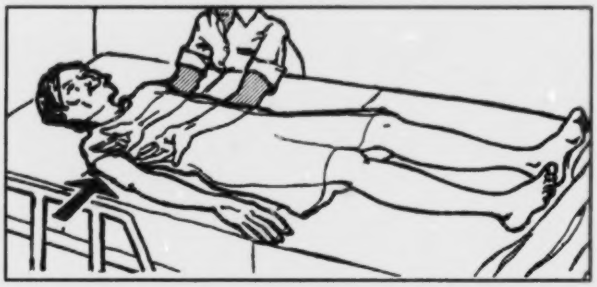
5. Raise bed to a comfortable working height. Lock wheels on bed. Lower backrest. Lower side rail on side at which you are working.

6. If the patient has any tubing coming from his body and it is pinned to the bedding, unfasten and arrange the tubing so that it will move freely with the patient.

7. Remove pillow. Fanfold top sheet to foot of bed. Make sure gown is covering patient so patient is not exposed.

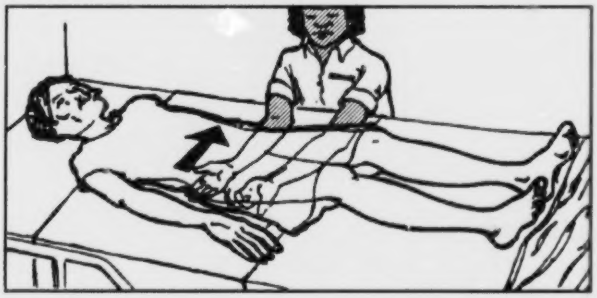
8. Stand on the side of the bed toward which you intend to move patient.

9. Slide both arms under the patient's back to his far shoulder, then slide the patient's shoulders toward you on your arms.

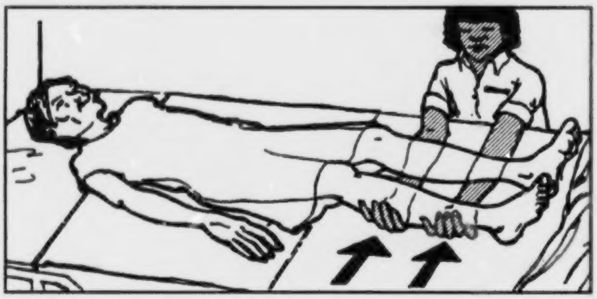


NOTE: Keep your knees bent and your back straight. Shift weight from front to back foot as you slide the patient.

10. Slide both your arms as far as you can under the patient's buttocks and slide his buttocks toward you. Use a lift sheet whenever possible.



11. Place both your arms under the patient's lower legs and slide them toward you on your arms.



12. Replace pillows.

13. Adjust backrest for comfort.

14. Lower bed to a position of safety; raise side rails if appropriate.

15. Make the patient comfortable. Place call signal within reach.

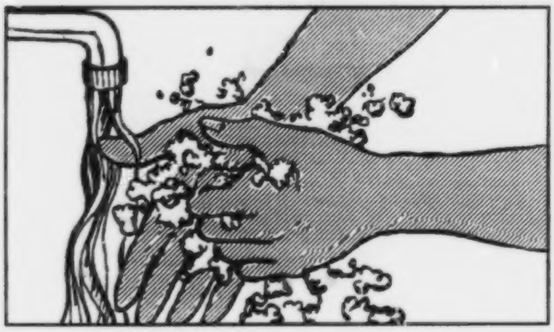
16. Fasten tubing if unpinned while moving patient. Adjust bedding.

17. Wash your hands.

F. Steps of Procedure for Turning the Patient on Side

1. Wash your hands.

NOTE: Wear gloves if there is a possibility of contact with wet linen, blood, or body fluids.

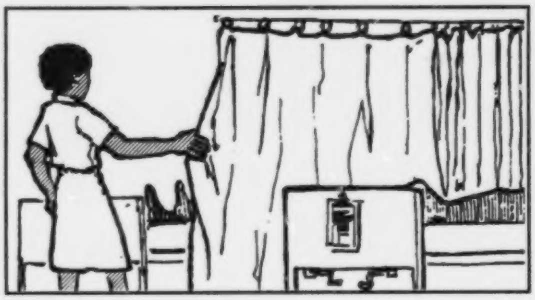


2. Bring three pillows and handroll or washcloth to bedside.

3. Identify and greet patient. Identify self.

4. Explain what you are going to do.

5. Provide privacy. Pull curtain around bed.



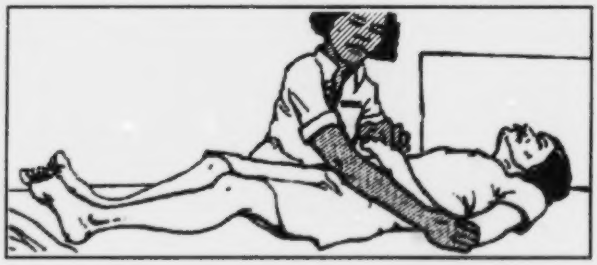
6. Raise bed to a comfortable working height. Lock wheels on bed. Lower backrest. Lower side rail on side from which you are working.

7. If the patient has any tubing coming from his body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the patient.

8. Remove pillow. Fanfold top sheet to foot of bed. Make sure gown is covering patient so patient is not exposed.

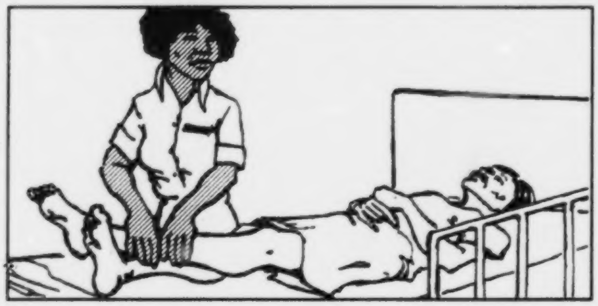
9. Check to see that the patient has ample space to turn without getting too close to the edge of the bed. If not, have patient move over more in bed, or you move the patient to the side of the bed that he is not turning to.

10. Cross the patient's arms over his chest.



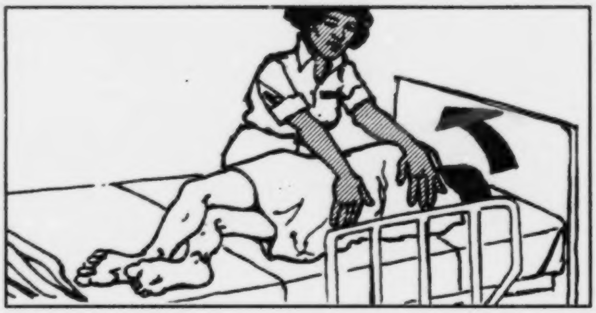
11. Turning patient toward you

    a. Cross the leg farthest from you over the leg closest to you.



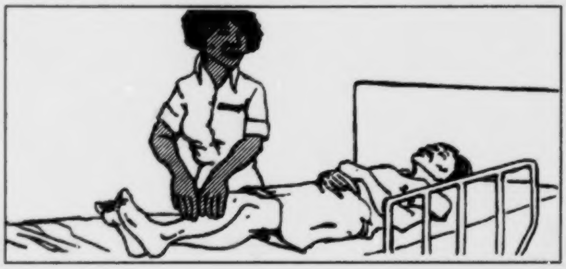
    b. Reach across the patient and put one hand behind his far shoulder.

    c. Place your other hand behind his far hip, gently roll him toward you.



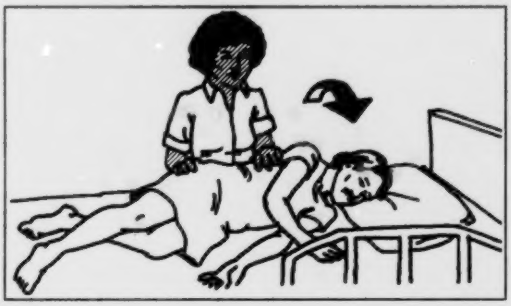
Turning patient away from you

a. Cross the leg closest to you over the leg farthest from you.

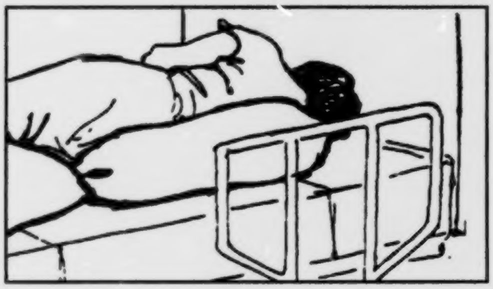


b. Place one hand on the patient's shoulder near you.

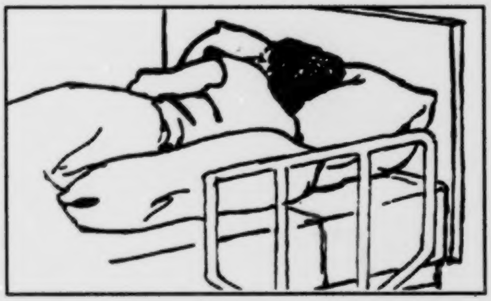
c. Put your other hand under patient's buttocks, turn him gently on his side, facing away from you.



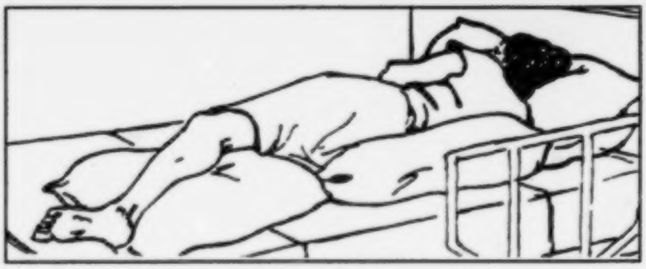
12. Fold a pillow lengthwise and place it against the patient's back for support.



13. Support the patient's head with the palm of one hand and slide a pillow under his head and neck with the other hand.



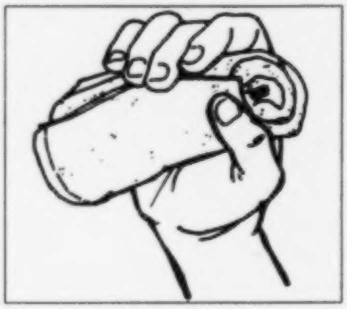
14. Position patient's knees slightly flexed, upper leg more than the lower leg. Support upper leg on pillow.



15. Support upper arm on pillow.

CAUTION: Be sure patient's lower arm is free from pressure.

16. Place handroll or rolled washcloth in hand with thumb in opposition to fingers if appropriate.



17. Make the patient comfortable. Place call signal within reach.

18. Fasten tubing if unpinned while moving patient. Adjust bedding.

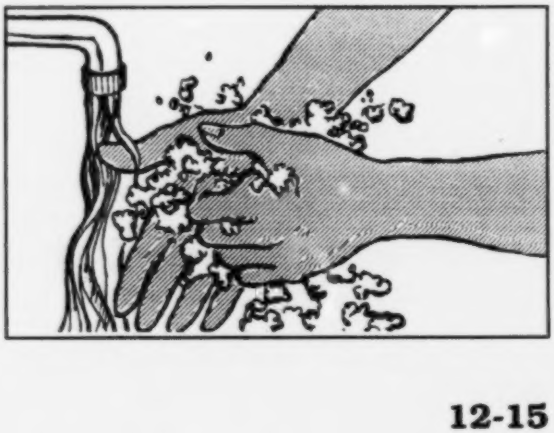
19. Lower bed to a position of safety. Raise side rails if appropriate.

20. Wash your hands.

G. Steps of Procedure for Turning Patient to Prone Position

1. Wash your hands.

NOTE: Wear gloves if there is a possibility of contact with wet linen, blood, or body fluids.

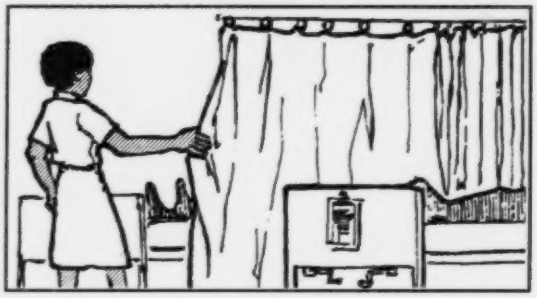


2. Bring three small pillows and handroll or washcloth to bedside.

3. Identify and greet patient. Identify self.

4. Explain what you are going to do.

5. Provide privacy. Pull curtain around bed.

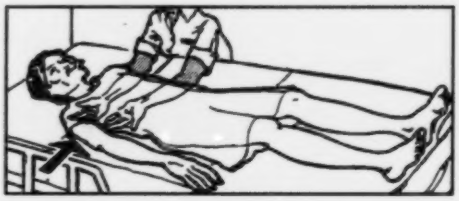


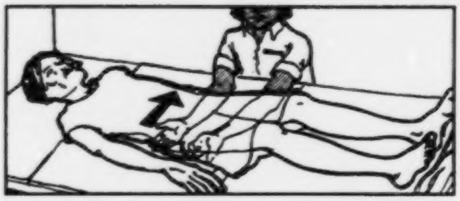
6. Raise bed to a comfortable working height. Lock wheels on bed. Lower backrest. Lower side rail on side from which you are working.

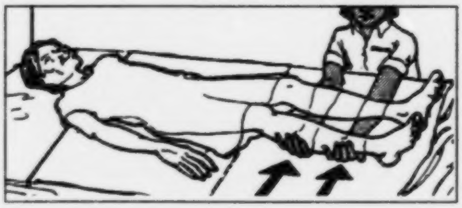
7. If the patient has any tubing coming from his body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the patient.

8. Remove pillows. Fanfold top sheet to foot of bed. Make sure gown is covering patient so patient is not exposed.

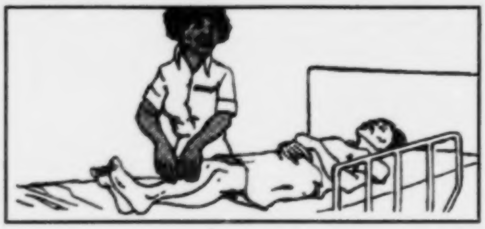
9. Move patient to side of bed you are on.

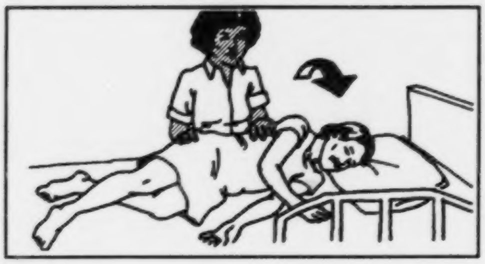






10. Turn patient on side away from you.





11. Move patient to side of bed you are on while patient is on side. Place one arm under patient's shoulder and your other arm under upper thigh. Move upper body to edge of bed.

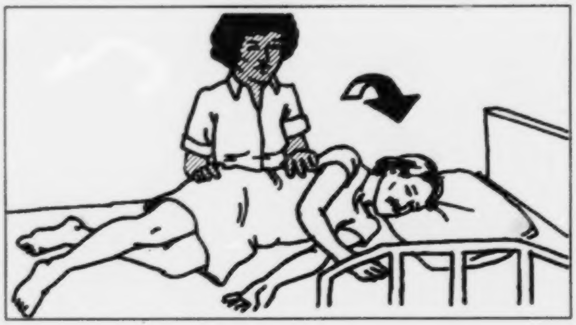
12. Place one arm above patient's knee and your other arm above patient's ankle. Move lower body to edge of bed.

13. Arm near center should be close to body at the side.

14. Make sure upper leg is still crossed over lower leg.

15. Roll patient away from you onto abdomen.

NOTE: Make sure arm is free of body after patient is rolled over.



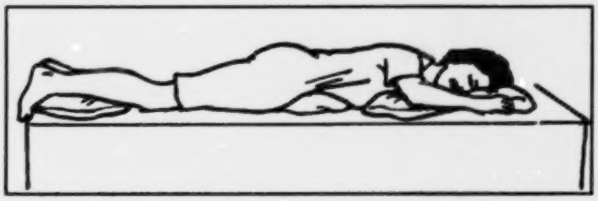
16. Place small, firm pillow/folded blanket under the head. Do not use a full pillow as it may cause neck strain and interfere with breathing.

CAUTION: Patients can smother if left unsupervised in prone position.

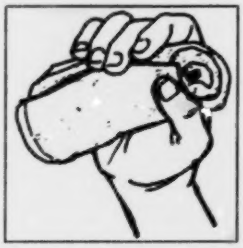
17. Place small, firm pillow under one shoulder.

18. For female patients, place small, firm pillow under abdomen to prevent pressure on breasts.

19. Extend feet over end of mattress or slightly elevate feet off mattress by flexing knees and placing pillow under lower legs.



20. Place handroll or rolled washcloth in hand with thumb in opposition to fingers if appropriate.



21. Make the patient comfortable. Place call signal within reach.

22. Fasten tubing if unpinned while moving patient. Adjust bedding.

23. Lower bed to a position of safety. Raise side rails if appropriate.

24. Wash your hands.

Body Mechanics
Written Evaluation

Circle the letter that corresponds to the best answer.

1. Good body mechanics help caregivers to:

   a. Avoid injury and fatigue.
   b. Drop fewer things.
   c. Hurt their backs more often.
   d. Lose weight.

2. When lifting an object, you should:

   a. Bend over and pick it up.
   b. Hold the object far away from you.
   c. Squat or kneel and lift with your leg muscles.
   d. Use only one hand.

3. If a patient is too heavy for you to move, you should:

   a. Move the patient anyway.
   b. Wait until the patient loses some weight.
   c. Leave and let someone else do it.
   d. Call for help.

Body Mechanics
Evaluation

______________________ has successfully performed the following steps of procedure.
(Student)

Assisting/Raising Patient's Head and Shoulders		Yes	No	Comments
1.	Wash your hands. **NOTE:** Wear gloves if there is a possibility of contact with wet linen, blood, or body fluids.			
2.	Identify and greet patient. Identify self.			
3.	Explain what you are going to do.			
4.	Provide privacy. Pull curtain around bed.			
5.	Raise bed to a comfortable working height. Lock wheels on bed. Lower backrest. Lower side rail on side at which you are working.			
6.	If the patient has any tubing coming from his body and it is pinned to the bedding, unfasten and arrange it so the tubing will move freely with the patient.			
7.	Face the head of the bed with your knees shoulder width apart. Bend your knees. Keep your back straight.			
8.	Instruct the patient to put his arm under your arm closest to him. Patient should put his arm behind your shoulder, with his hand over the top of your shoulder. **NOTE:** If you are standing at his right side, patient's right hand will be on your right shoulder. If you are on his left, patient's left hand would be on your left shoulder.			
9.	Put your arm under the patient's arm with your hand on his shoulder. Thus, you will lock arms with the patient.			
10.	Put your other arm around the patient's shoulders.			
11.	Count one, two, three. On three, help the patient pull himself up as you support him and he raises his head and shoulders.			
12.	Turn or replace the pillow with the hand you have around the patient's neck and shoulder.			
13.	Help the patient gently lie down again, supporting him with your locked arm and the arm around his neck and shoulder.			
14.	Make the patient comfortable. Place call light within reach.			
15.	Raise side rails if appropriate. Lower the bed to a position of safety for the patient.			
16.	Open curtain.			
17.	Wash your hands.			

Moving/Assisting Patient to Head of Bed		Yes	No	Comments
1.	Wash your hands. **NOTE:** Wear gloves if there is a possibility of contact with wet linen, blood, or body fluids.			
2.	Identify and greet patient. Identify self.			
3.	Explain what you are going to do.			
4.	Provide privacy. Pull curtain around bed.			
5.	Raise bed to a comfortable working height. Lock wheels on bed. Lower backrest. Lower side rail on side at which you are working.			
6.	If the patient has any tubing coming from his body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the patient.			
7.	Move pillow to headboard so patient does not hit his head when moving up. Fanfold top covers to foot of bed.			
8.	Help patient bend his knees and press feet firmly against the mattress.			
9.	If patient is able, have him grasp head of bed, otherwise cross his arms over chest.			
10.	Slide one arm under patient's shoulders and the other under the thighs.			
11.	Stand facing head of the bed with your feet 18 inches apart. One foot should be slightly ahead of the other.			
12.	On the count of three, have the patient push with his feet and you shift your weight from your back leg to your front leg as you slide the patient up in the bed.			
13.	Replace pillows.			
14.	Adjust backrest for comfort.			
15.	Lower bed to a position of safety. Raise side rails if appropriate.			
16.	Make the patient comfortable. Place call signal within reach.			
17.	Fasten tubing if unpinned while moving patient. Adjust bedding.			
18.	Wash your hands.			
Moving Helpless Patient to Head of Bed				
1.	Wash hands. **NOTE:** Wear gloves if there is a possibility of contact with wet linen, blood, or body fluids.			
2.	Ask another nurse assistant to work with you.			
3.	Identify and greet patient. Identify self and other nurse assistant. Explain what you are going to do.			
4.	Provide privacy. Pull curtain around bed.			
5.	Raise bed to a comfortable working height. Lock wheels on bed. Lower backrest. Lower side rail on side at which you are working.			

Moving Patient to Head of Bed Cont.		Yes	No	Comments
6.	If the patient has any tubing coming from his body and it is pinned to the bedding, unfasten and arrange the tubing so that it will move freely with the patient.			
7.	Move pillow to headboard so patient does not hit his head when moving up. Fanfold top sheet to foot of bed. Make sure gown is covering patient so patient is not exposed.			
8.	Nurse assistants should stand on opposite sides of the bed.			
9.	Position a draw sheet/folded regular sheet under shoulders and hip area. Each nurse assistant should roll edges of sheet toward patient's body and grasp rolled sheet at the patient's shoulders and at the mid-hip area.			
10.	Your feet should be pointed in the direction you are moving the patient. Bend knees, keep back straight.			
11.	On the count of three, each nurse assistant lifts the patient up off the surface of the bed and toward the head of the bed while shifting weight from back foot to front foot.			
12.	Replace pillow.			
13.	Adjust backrest for comfort.			
14.	Lower bed to a position of safety. Raise side rails if appropriate.			
15.	Make the patient comfortable. Place call signal within reach.			
16.	Fasten tubing if unpinned while moving patient. Adjust bedding.			
17.	Wash your hands.			
Moving Patient to Side of the Bed				
1.	Wash your hands. **NOTE:** Wear gloves if there is a possibility of contact with wet linen, blood, or body fluids.			
2.	Identify and greet patient. Identify self.			
3.	Explain what you are going to do.			
4.	Provide privacy. Pull curtain around bed.			
5.	Raise bed to a comfortable working height. Lock wheels on bed. Lower backrest. Lower side rail on side at which you are working.			
6.	If the patient has any tubing coming from his body and it is pinned to the bedding, unfasten and arrange the tubing so that it will move freely with the patient.			
7.	Remove pillow. Fanfold top sheet to foot of bed. Make sure gown is covering patient so patient is not exposed.			
8.	Stand on the side of the bed toward which you intend to move patient.			
9.	Slide both arms under the patient's back to his far shoulder, then slide the patient's shoulders toward you on your arms. **NOTE:** Keep your knees bent and your back straight. Shift weight from front to back foot as you slide the patient.			

Moving Patient to Side of the Bed Cont.		**Yes**	**No**	**Comments**
10.	Slide both your arms as far as you can under the patient's buttocks and slide his buttocks toward you. Use a lift sheet whenever possible.			
11.	Place both your arms under the patient's lower legs and slide them toward you on your arms.			
12.	Replace pillows.			
13.	Adjust backrest for comfort.			
14.	Lower bed to a position of safety; raise side rails if appropriate.			
15.	Make the patient comfortable. Place call signal within reach.			
16.	Fasten tubing if unpinned while moving patient. Adjust bedding.			
17.	Wash your hands.			
Turning the Patient on Side				
1.	Wash your hands. **NOTE:** Wear gloves if there is a possibility of contact with wet linen, blood, or body fluids.			
2.	Bring three pillows and handroll or washcloth to bedside.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Provide privacy. Pull curtain around bed.			
6.	Raise bed to a comfortable working height. Lock wheels on bed. Lower backrest. Lower side rail on side from which you are working.			
7.	If the patient has any tubing coming from his body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the patient.			
8.	Remove pillow. Fanfold top sheet to foot of bed. Make sure gown is covering patient so patient is not exposed.			
9.	Check to see that the patient has ample space to turn without getting too close to the edge of the bed. If not, have patient move over more in bed, or you move the patient to the side of the bed that he is not turning to.			
10.	Cross the patient's arms over his chest.			
11.	Turning patient toward you			
	a. Cross the leg farthest from you over the leg closest to you.			
	b. Reach across the patient and put one hand behind his far shoulder.			
	c. Place your other hand behind his far hip, gently roll him toward you.			
	Turning patient away from you			
	a. Cross the leg closest to you over the leg farthest from you.			
	b. Place one hand on the patient's shoulder near you.			

Turning the Patient on Side Cont.		Yes	No	Comments
	c. Put your other hand under patient's buttocks, turn him gently on his side, facing away from you.			
12.	Fold a pillow lengthwise and place it against the patient's back for support.			
13.	Support the patient's head with the palm of one hand and slide a pillow under his head and neck with the other hand.			
14.	Position patient's knees slightly flexed, upper leg more than the lower leg. Support upper leg on pillow.			
15.	Support upper arm on pillow. **CAUTION:** Be sure patient's lower arm is free from pressure.			
16.	Place handroll or rolled washcloth in hand with thumb in opposition to fingers if appropriate.			
17.	Make the patient comfortable. Place call signal within reach.			
18.	Fasten tubing if unpinned while moving patient. Adjust bedding.			
19.	Lower bed to a position of safety. Raise side rails if appropriate.			
20.	Wash your hands.			
Turning Patient to Prone Position				
1.	Wash your hands. **NOTE:** Wear gloves if there is a possibility of contact with wet linen, blood, or body fluids.			
2.	Bring three small pillows and handroll or washcloth to bedside.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Provide privacy. Pull curtain around bed.			
6.	Raise bed to a comfortable working height. Lock wheels on bed. Lower backrest. Lower side rail on side from which you are working.			
7.	If the patient has any tubing coming from his body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the patient.			
8.	Remove pillows. Fanfold top sheet to foot of bed. Make sure gown is covering patient so patient is not exposed.			
9.	Move patient on side of bed you are on.			
10.	Turn patient to side away from you.			
11.	Move patient to side of bed you are on while patient is on side. Place one arm under patient's shoulder and your other arm under upper thigh. Move upper body to edge of bed.			
12.	Place one arm above patient's knee and your other arm above patient's ankle. Move lower body to edge of bed.			
13.	Arm near center should be close to body at the side.			

Turning Patient to Prone Position Cont.		Yes	No	Comments
14.	Make sure upper leg is still crossed over lower leg.			
15.	Roll patient away from you onto abdomen. **NOTE:** Make sure arm is free of body after patient is rolled over.			
16.	Place small, firm pillow/folded blanket under the head. Do not use a full pillow as it may cause neck strain and interfere with breathing. **CAUTION:** Patients can smother if left unsupervised in prone position.			
17.	Place small, firm pillow under one shoulder.			
18.	For female patients, place small, firm pillow under abdomen to prevent pressure on breasts.			
19.	Extend feet over end of mattress or slightly elevate feet off mattress by flexing knees and placing pillow under lower legs.			
20.	Place handroll or rolled washcloth in hand with thumb in opposition to fingers if appropriate.			
21.	Make the patient comfortable. Place call signal within reach.			
22.	Fasten tubing if unpinned while moving patient. Adjust bedding.			
23.	Lower bed to a position of safety. Raise side rails if appropriate.			
24.	Wash your hands.			

Student's Signature/Date

Instructor's Signature/Date

Transferring the Patient

Unit Objective

After completing this unit, you should be able to transfer a patient from bed to chair, from chair to bed, and using a mechanical lift.

Specific Objectives

After completing this unit, you should be able to:

A. Match terms presented in this unit to their correct definitions.

B. Identify safety measures when transferring a patient.

C. Transfer a patient from bed to chair according to steps of procedure.

D. Transfer a patient from chair to bed according to steps of procedure.

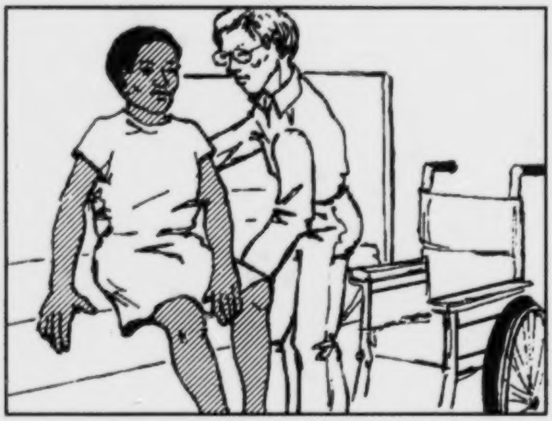
E. Transfer a patient from bed to chair with a mechanical lift according to steps of procedure.

F. Transfer a patient from chair to bed with a mechanical lift according to steps of procedure.

Introduction

Patients who spend a lot of time in bed sometimes become weak. For that reason, patients who are allowed to be out of bed should get up several times. Some patients will need assistance to do this by their caregiver. Sometimes, the caregiver will need to use a mechanical lift.

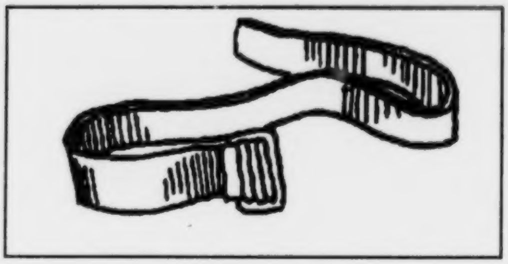
In this unit, you will learn to how transfer a patient from bed to chair, from chair to bed, and using a mechanical lift.



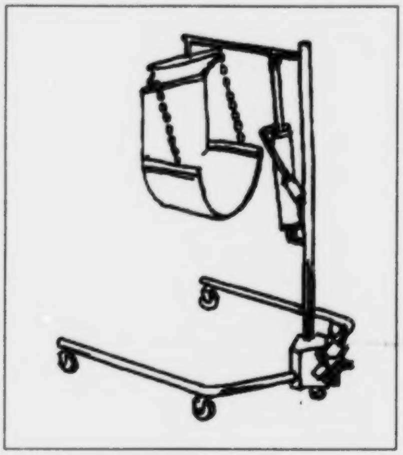
A. Terms

Transfer - method of moving a patient from one area to another

Gait belt - a special transfer belt that is placed around the patient's waist and acts as a handle to hold on to when moving the patient



Mechanical lift - a device used to lift and move patients who are unable to do so on their own



Pivot - to turn

B. Safety Measures for Transferring Patients

- When transferring a patient who has a weak side, position the chair on his strong side.
- For a weak patient, you need to have control of the shoulders and hips during transfer.
- Do not attempt to transfer a patient who cannot bear any of his own body weight by yourself. Determine beforehand how many people will be needed for the transfer.
- All wheelchairs should have locks that are locked during transfer; a slight movement of the wheelchair could cause a fall.

- Footrests should be up and out of the way during transfer to prevent the patient from tripping or stepping on the rests and falling.

- Have all equipment handy and checked for safety before beginning procedures.

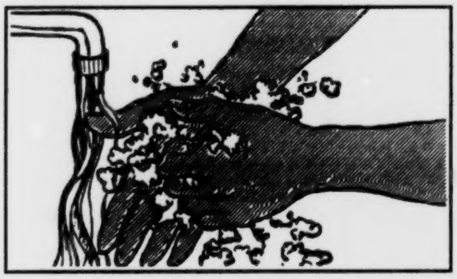
- Give the patient a thorough explanation of how he is to assist. Give patient encouragement and praise when he assists with the transfer.

- Patient's feet should be flat on the floor approximately 12 inches apart.

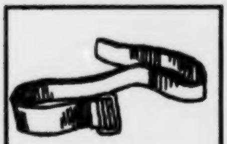
- Practice good body mechanics.

C. Steps of Procedure for Transferring Patient From Bed to Chair or Wheelchair

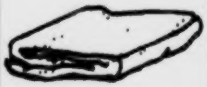
1. Wash your hands.



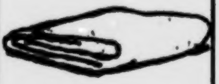
2. Assemble equipment.



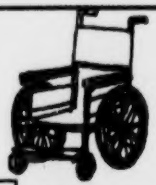
☐ Gait belt



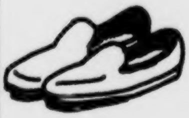
☐ Lap robe



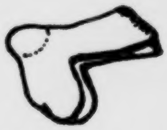
☐ Bath blanket



☐ Wheelchair

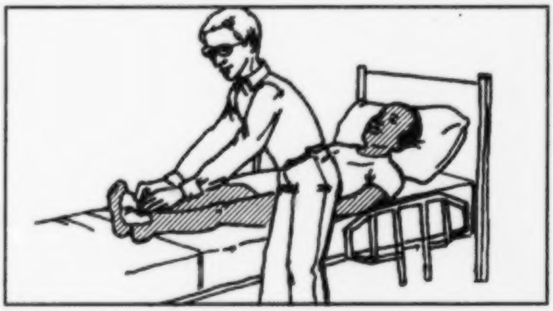


☐ Non-skid shoes

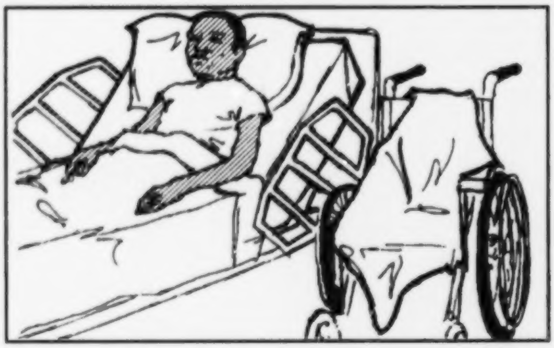


☐ Socks

3. Identify and greet patient. Identify self.
4. Explain what you are going to do.
5. Provide privacy. Pull curtain around bed.
6. Adjust bed height to low position. Lock brakes of bed. Lower side rail.
7. May raise head of bed if allowed to bring patient to sitting position.
8. Assist patient to move over in bed to within five or six inches of the edge of the bed.
9. Assist patient in putting on socks and nonskid shoes.



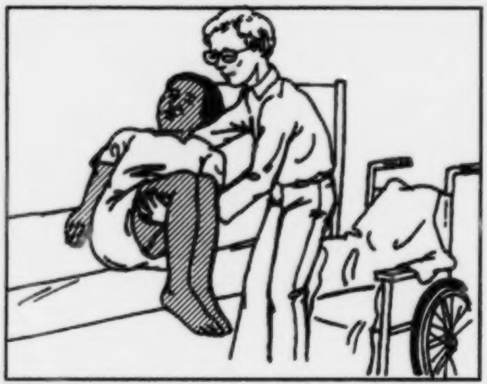
10. Position wheelchair (W/C) or geri chair (G/C) or commode on patient's strong side if indicated. If not, position chair as desired.
11. Place chair parallel to or at a 45° angle to the bed.
12. Lock the wheels of the chair.
13. Cover W/C or G/C with bath blanket and/or protective pad. Raise footrests and remove if possible. If possible, remove the armrest on the side next to the bed.



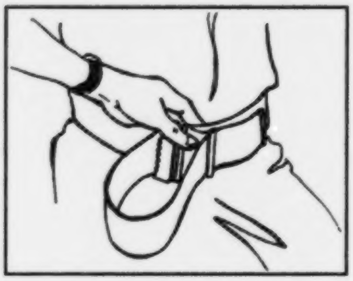
14. Position your body facing foot of bed.
15. Put one forearm under patient's shoulders and the other behind the knees.

16. Bend your knees, keep your back straight, and stand with feet about 18 inches apart.

17. Straighten your hips and knees while shifting weight from front foot to back foot. At the same time, lift patient's head-neck with one arm while pulling the legs over the side of bed with other arm.

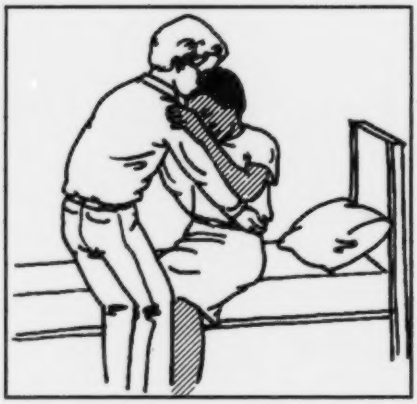


18. Apply gait belt.

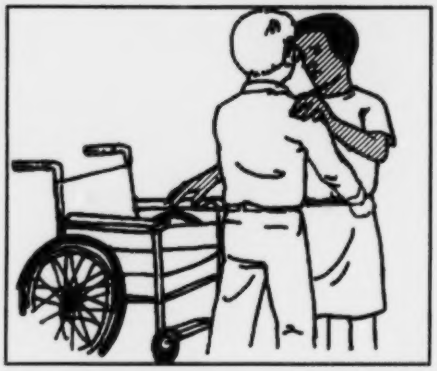


19. Allow the patient time for his circulation to adjust to being in a sitting position before you proceed. Assist the patient in maintaining a sitting position as needed.

20. **If Patient is able to assist**
    a. Place hands underneath belt along the patient's side with palms up.
    b. Instruct patient to stand on the count of three.
    c. Assist patient to stand and support the weak leg with your knee, if indicated.



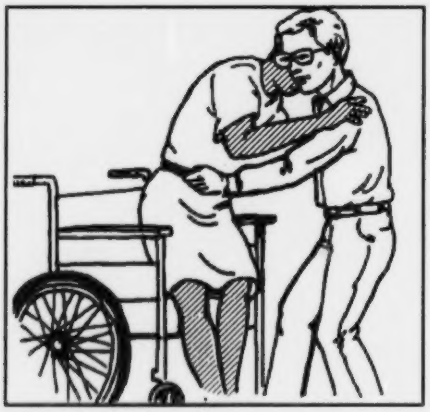
d. Instruct patient to reach with his strong hand and grasp for the far armrest of the chair.



e. Assist the patient to pivot toward his strong leg by turning your own body.

CAUTION: Do not twist, turn your body as a unit.

f. Gently assist patient to sit by bending your knees while keeping your back straight.



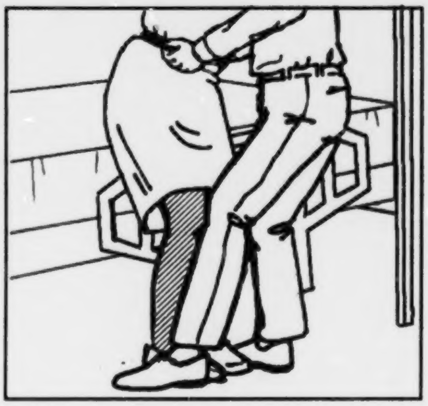
g. Position the weak arm and leg properly on the armrest and footrest. A pillow may be used to support the weak arm.

h. Remove gait belt.

If Patient is unable to assist

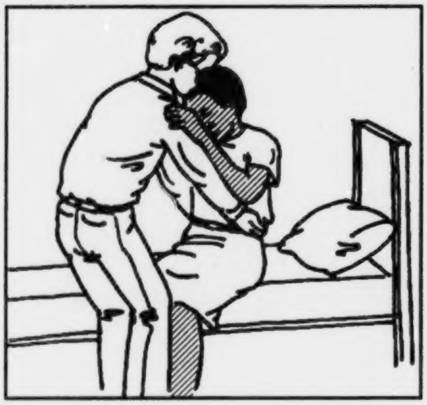
a. Stand directly in front of the patient, grasp the back of the belt.

b. Support the patient's knees and feet with your knees and feet, either knee-to-knee or your knees on the sides of the patient's knees, whatever is comfortable for you and the patient.



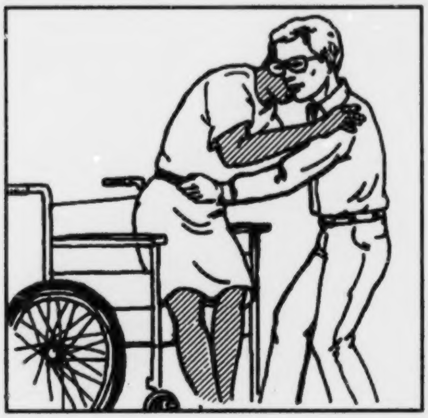
c. Have the patient lean forward while sitting on the edge of the bed.

d. On the count of three, have the patient push up as much as possible while you pull him up by straightening your legs and hips and holding onto the belt.

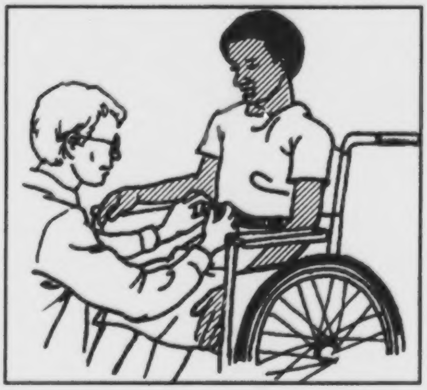


e. Pivot your entire body as well as the patient's.

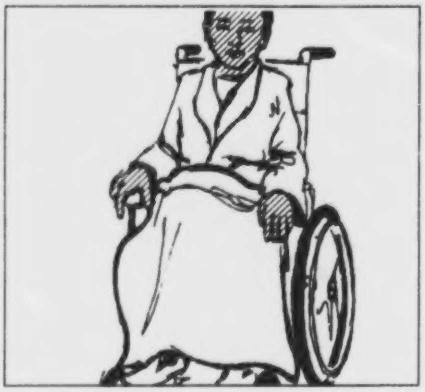
f. Lower the patient into the chair by bending at your knees and hips as the patient sits down.



g. Remove gait belt.



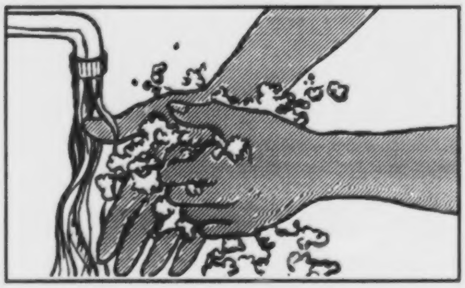
h. Adjust footrest for patient. Cover patient with a lap robe.



i. Position pillow(s) to provide proper body alignment and joint support.

21. Make patient comfortable and place call light within reach.

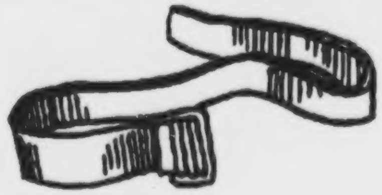
22. Wash your hands.



23. Report anything unusual to charge nurse.

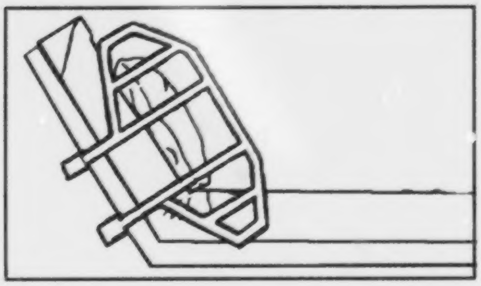
D. Steps of Procedure For Transferring Patient From Chair to Bed

1. Wash your hands.
2. Assemble equipment.

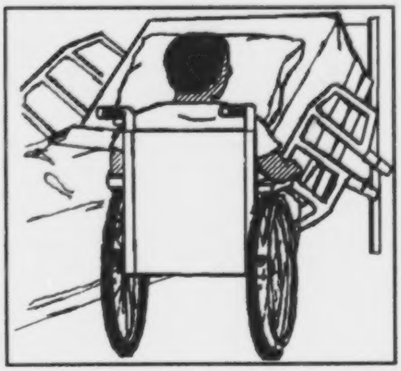


☐ Gait belt

3. Identify and greet patient. Identify self.
4. Explain what you are going to do.
5. Provide privacy. Pull curtain around bed.
6. Adjust bed height to low position. Lock brakes of bed.
7. Raise head of bed and fanfold bed linens to end of bed. Make sure opposite side rail is raised.



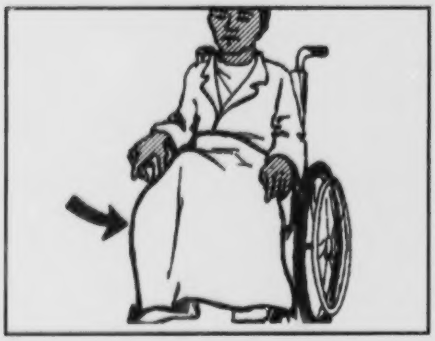
8. Position chair at foot of bed with chair facing head of bed.



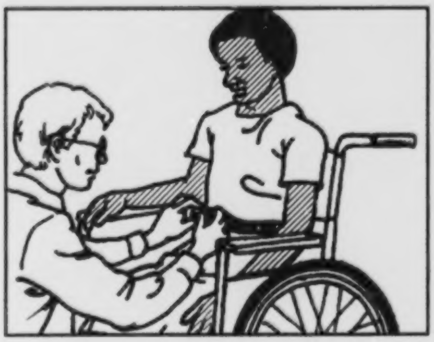
9. Lock wheels and bring up footrests.

10. Place patient's feet on floor.

11. Remove lap robe/blanket.

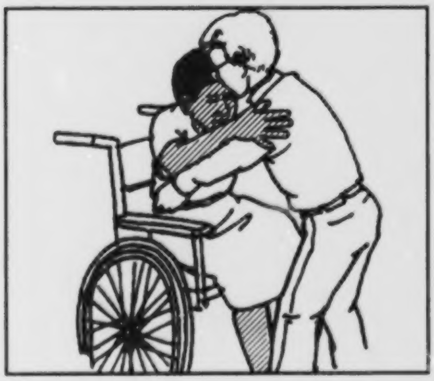


12. Apply gait belt.

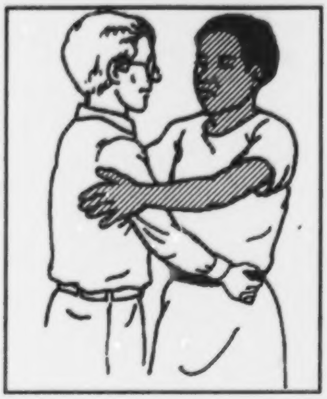


13. Stand in front of patient with feet about 18 inches apart.

14. Place your hands underneath belt. If patient is able, have him place hands on chair armrest and push.

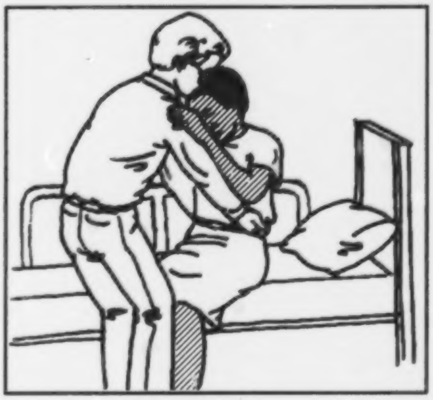


15. Assist patient to stand.



16. Pivot your body and the patient's body toward the bed.

17. Slowly lower patient to sitting position on the bed.

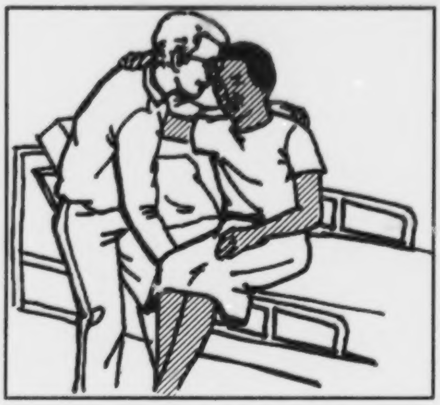


18. Remove gait belt.

19. Position your body facing the head of the bed. One foot should be in front of the other foot.

20. Place one forearm on patient's shoulders and the other behind the patient's knees.

21. Swing/assist patient's legs onto the bed as you pivot the patient's body.



22. Lower head of bed.

23. Move/assist patient to center of bed.

24. Remove slippers.

25. Cover patient, position pillows, and straighten bed linens.

26. Make patient comfortable. Place call light within reach.

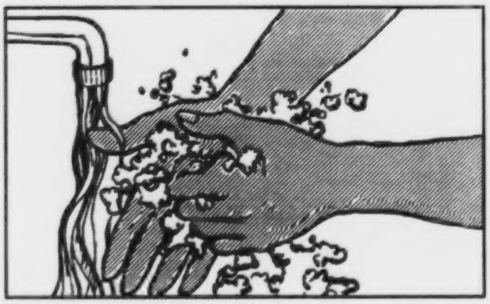
27. Wash your hands.

28. Report anything unusual to charge nurse.

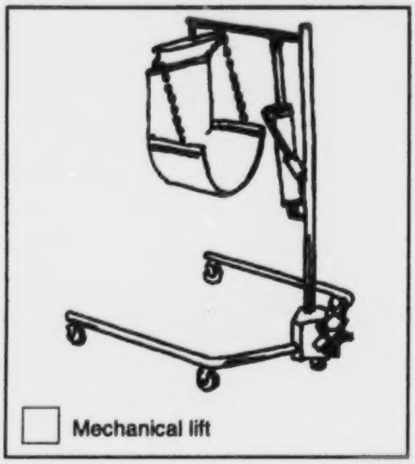
E. Steps of Procedure for Transferring Patient From Bed to Chair Using a Mechanical Lift

1. Ask for assistance from another health care assistant.

2. Wash your hands.



3. Assemble equipment.



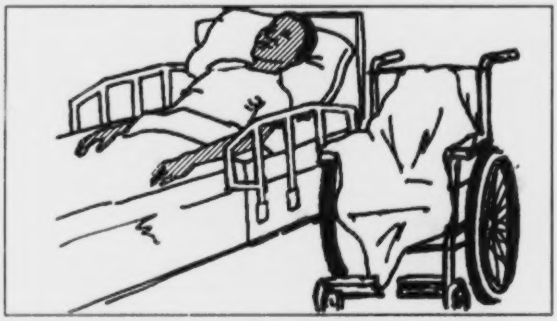
4. Identify and greet patient. Identify self and other health care assistant.

5. Explain what you are going to do.

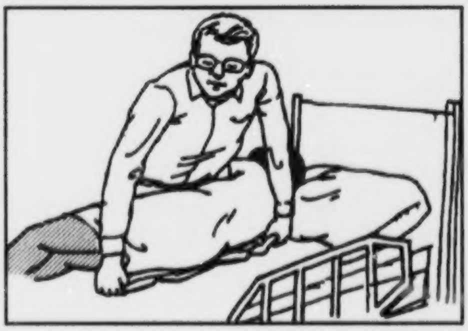
6. Provide privacy. Pull curtain around bed.

7. Adjust bed height to low position. Lock brakes of bed.

8. Position chair next to bed with the back of chair in line with the headboard of the bed.

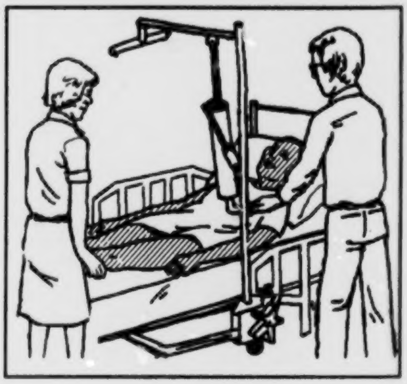


9. By turning the patient from side to side on the bed, you can slide the sling under the patient.

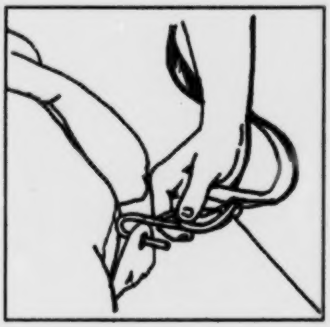


NOTE: Make sure the top of the sling is at the crest of the shoulders and the bottom is above the bend of the knees.

10. Wheel the lift into place over the patient with the base beneath the bed and be sure to lock the wheels of the lift.



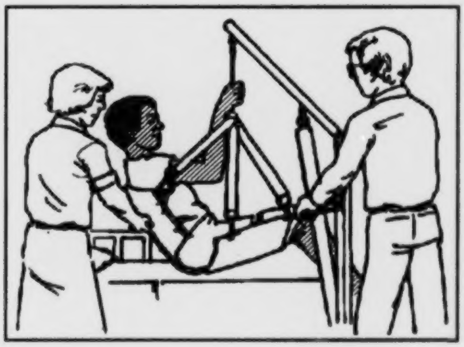
11. Attach the sling to the mechanical lift with the hooks in place under the metal frame.



NOTE: Be sure to apply hooks with open, sharp ends away from the patient.

12. Have the patient fold both arms across chest, if possible.

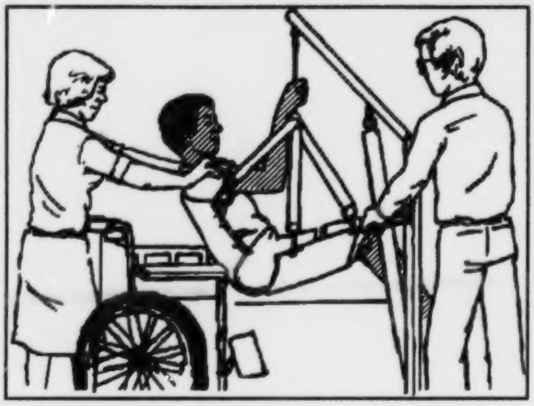
13. Using the crank, lift the patient until the buttocks are clear of the bed. Make sure the patient is aligned in the sling and is securely suspended in a sitting position with legs dangling over the bottom of the sling.



14. One health care assistant should guide the patient's legs over the edge of the bed. Release brakes on mechanical lift.

15. Move the lift away from the bed, turn the patient so that he faces you while the other health care assistant guides the patient's body toward the chair by standing behind the patient.

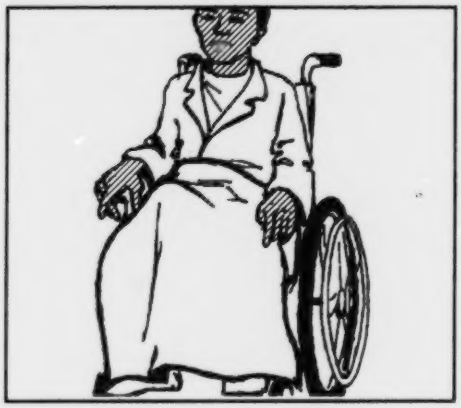
16. Open the support legs of the lift with the control lever, then bring the lift into position so that the patient is over the seat of the chair.



17. Release the control knob slowly so that the patient will gradually be lowered into chair.

18. Remove the hooks from the frame of the lift.

19. Cover patient with lap robe or blanket.



20. Secure the patient to the chair with safety restraint if ordered.

21. Make the patient comfortable. Place call light within reach.

22. Store lift properly until time to transfer patient again.

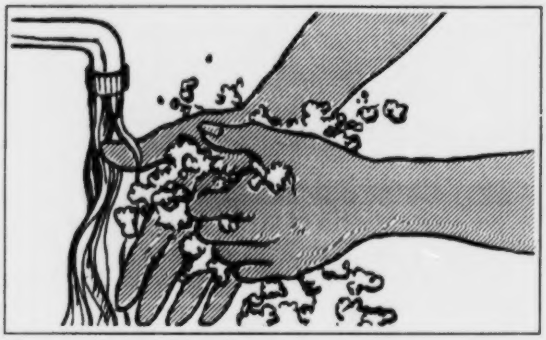
23. Wash your hands.

24. Report anything unusual to charge nurse.

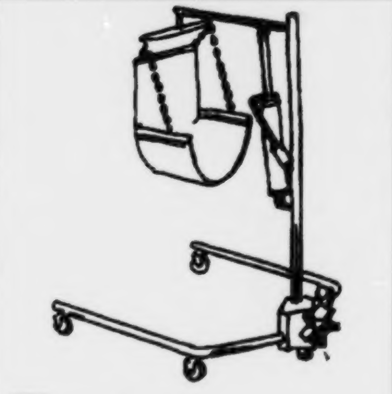
F. Steps of Procedure for Transferring Patient from Chair to Bed Using a Mechanical Lift

1. Ask for assistance from another health care assistant.

2. Wash your hands.



3. Assemble equipment.



☐ Mechanical lift

4. Identify and greet patient. Identify self and other health care assistant.

5. Explain what you are going to do.

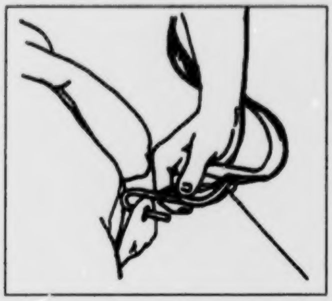
6. Provide privacy. Pull curtain around bed.

7. Adjust bed height to low position. Lock brakes of bed.

8. Position chair next to bed with the back of chair in line with the headboard of the bed.

9. Wheel the lift into place over the patient with the base beneath the chair. Lock the wheels of the lift.

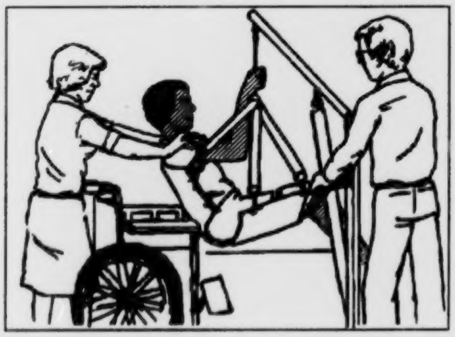
10. Put the hooks through the metal frame of the sling, which is still under the patient.



NOTE: Be sure to apply hooks with open, sharp ends away from the patient.

11. Have the patient fold both arms across chest if possible.

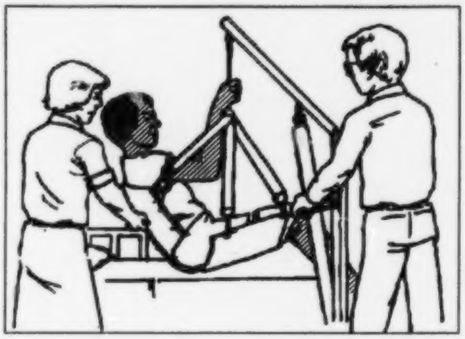
12. Using the crank, lift the patient until the buttocks are clear of the chair. Make sure the patient is aligned in the sling and is securely suspended in a sitting position with legs dangling over the bottom of the sling.



13. Have your partner, a second heath care assistant, stand behind the chair and guide the patient's body over the side of the chair; release brakes on mechanical lift.

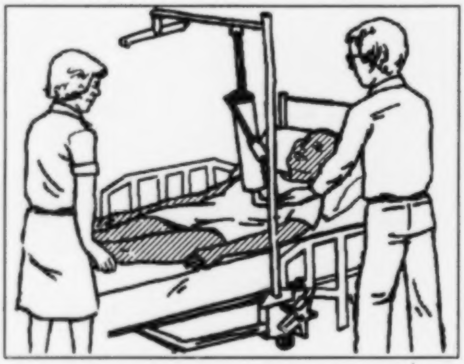
14. Move the lift away from the chair. Turn the patient in the sling toward the bed with the second health care assistant guiding the patient's body.

15. Open the support legs of the lift with the control lever, then bring the lift into position so that the patient is over the center of the bed. Lock the wheels on the lift.



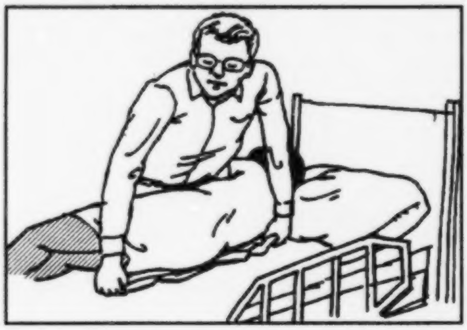
16. Release the control knob slowly so that the patient will gradually be lowered onto the bed.

17. Remove the hooks from the frame of the lift.



18. Unlock wheels on lift. Move the lift away from the bed.

19. Remove the sling from under the patient by having him turn from side to side on the bed.



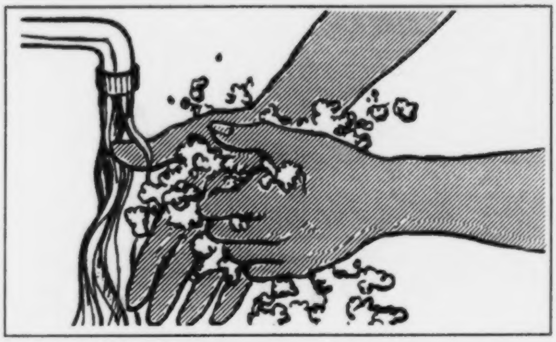
20. Put a pillow under the patient's head. Remake the top of the bed.

21. Make the patient comfortable. Place call light within patient's reach.

22. Pull up side rails if appropriate and lower bed to its lowest position.

23. Open curtain.

24. Wash your hands.



25. Record observations and report anything unusual to the charge nurse.

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Transferring the Patient
Written Evaluation

Match terms in Column A with definitions in Column B.

Column A

_____ 1. Transfer

_____ 2. Pivot

_____ 3. Mechanical Lift

_____ 4. Gait Belt

Column B

a. To turn
b. Method of moving a patient from one area to another
c. A special transfer belt that is placed around the patient's waist and acts as a handle to hold on to when moving the patient
d. A device used to lift and move patients who are unable to do so on their own

Circle the letter than corresponds to the best answer.

5. When transferring a patient who has a weak side, the health care assistant would position the chair on the side of the patient that is:

   a. Weak.
   b. Strong.
   c. Right.
   d. Left.

6. When transferring a weak patient, the shoulders and what must be controlled?

   a. The arms must be controlled.
   b. The legs must be controlled.
   c. The hips must be controlled.
   d. The head must be controlled.

Transferring the Patient
Evaluation

____________________ has successfully performed the following steps of procedure.
(Student)

Transferring a Patient From Bed to Chair		Yes	No	Comments
1.	Wash your hands.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Provide privacy. Pull curtain around bed.			
6.	Adjust bed height to low position. Lock brakes of bed. Lower side rail.			
7.	May raise head of bed if allowed to bring patient to sitting position.			
8.	Assist patient to move over in bed to within five or six inches of the edge of the bed.			
9.	Assist patient in putting on socks and nonskid shoes.			
10.	Position wheelchair (W/C) or geri chair (G/C) or commode on patient's strong side if indicated. If not, position chair as desired.			
11.	Place chair parallel to or at a 45° angle to the bed.			
12.	Lock the wheels of the chair.			
13.	Cover W/C or G/C with bath blanket and/or protective pad. Raise footrests and remove if possible. If possible, remove the armrest on the side next to the bed.			
14.	Position your body facing foot of bed.			
15.	Put one forearm under patient's shoulders and the other behind the knees.			
16.	Bend your knees, keep your back straight, and stand with feet about 18 inches apart.			
17.	Straighten your hips and knees while shifting weight from front foot to back foot. At the same time, lift patient's head-neck with one arm while pulling the legs over the side of bed with other arm.			
18.	Apply gait belt.			
19.	Allow the patient time for his circulation to adjust to being in a sitting position before you proceed. Assist the patient in maintaining a sitting position as needed.			
20.	**If Patient is able to assist**			
	a. Place hands underneath belt along the patient's side with palms up.			

Transferring a Patient From Bed to Chair Cont.		Yes	No	Comments
	b. Instruct patient to stand on the count of three.			
	c. Assist patient to stand and support the weak leg with your knee, if indicated.			
	d. Instruct patient to reach with his strong hand and grasp for the far armrest of the chair.			
	e. Assist the patient to pivot toward his strong leg by turning your own body. **CAUTION:** Do not twist, turn your body as a unit.			
	f. Gently assist patient to sit by bending your knees while keeping your back straight.			
	g. Position the weak arm and leg properly on the armrest and footrest. A pillow may be used to support the weak arm.			
	h. Remove gait belt.			
	If Patient is unable to assist			
	a. Stand directly in front of the patient, grasp the back of the belt.			
	b. Support the patient's knees and feet with your knees and feet, either knee-to-knee or your knees on the sides of the patient's knees, whatever is comfortable for you and the patient.			
	c. Have the patient lean forward while sitting on the edge of the bed.			
	d. On the count of three, have the patient push up as much as possible while you pull him up by straightening your legs and hips and holding onto the belt.			
	e. Pivot your entire body as well as the patient's.			
	f. Lower the patient into the chair by bending at your knees and hips as the patient sits down.			
	g. Remove gait belt.			
	h. Adjust footrest for patient. Cover patient with a lap robe.			
	i. Position pillows to provide proper body alignment and joint support.			
21.	Make patient comfortable and place call light within reach.			
22.	Wash your hands.			
23.	Report anything unusual to charge nurse.			
Transferring Patient From Chair to Bed				
1.	Wash your hands.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Provide privacy. Pull curtain around bed.			

Transferring Patient From Chair to Bed Cont.		Yes	No	Comments
6.	Adjust bed height to low position. Lock brakes of bed.			
7.	Raise head of bed and fanfold bed linens to end of bed. Make sure opposite side rail is raised.			
8.	Position chair at foot of bed with chair facing head of bed.			
9.	Lock wheels and bring up footrests.			
10.	Place patient's feet on floor.			
11.	Remove lap robe/blanket.			
12.	Apply gait belt.			
13.	Stand in front of patient with feet about 18 inches apart.			
14.	Place your hands underneath belt. If patient is able, have him place hands on chair armrest and push.			
15.	Assist patient to stand.			
16.	Pivot your body and the patient's body toward the bed.			
17.	Slowly lower patient to sitting position on the bed.			
18.	Remove gait belt.			
19.	Position your body facing the head of the bed. One foot should be in front of the other foot.			
20.	Place one forearm on patient's shoulders and the other behind the patient's knees.			
21.	Swing/assist patient's legs onto the bed as you pivot the patient's body.			
22.	Lower head of bed.			
23.	Move/assist patient to center of bed.			
24.	Remove slippers.			
25.	Cover patient, position pillows, and straighten bed linens.			
26.	Make patient comfortable. Place call light within reach.			
27.	Wash your hands.			
28.	Report anything unusual to charge nurse.			
Transferring Patient From Bed to Chair Using a Mechanical Lift				
1.	Ask for assistance from another health care assistant.			
2.	Wash your hands.			
3.	Assemble equipment.			
4.	Identify and greet patient. Identify self and other health care assistant.			
5.	Explain what you are going to do.			

Transferring Patient From Bed to Chair Using a Mechanical Lift Cont.		Yes	No	Comments
6.	Provide privacy. Pull curtain around bed.			
7.	Adjust bed height to low position. Lock brakes of bed.			
8.	Position chair next to bed with the back of chair in line with the headboard of the bed.			
9.	By turning the patient from side to side on the bed, you can slide the sling under the patient. **NOTE:** Make sure the top of the sling is at the crest of the shoulders and the bottom is above the bend of the knees.			
10.	Wheel the lift into place over the patient with the base beneath the bed and be sure to lock the wheels of the lift.			
11.	Attach the sling to the mechanical lift with the hooks in place under the metal frame. **NOTE:** Be sure to apply hooks with open, sharp ends away from the patient.			
12.	Have the patient fold both arms across chest, if possible.			
13.	Using the crank, lift the patient until the buttocks are clear of the bed. Make sure the patient is aligned in the sling and is securely suspended in a sitting position with legs dangling over the bottom of the sling.			
14.	One health care assistant should guide the patient's legs over the edge of the bed. Release brakes on mechanical lift.			
15.	Move the lift away from the bed, turn the patient so that he faces you while the other health care assistant guides the patient's body toward the chair by standing behind the patient.			
16.	Open the support legs of the lift with the control lever, then bring the lift into position so that the patient is over the seat of the chair.			
17.	Release the control knob slowly so that the patient will gradually be lowered into chair.			
18.	Remove the hooks from the frame of the lift.			
19.	Cover patient with lap robe or blanket.			
20.	Secure the patient to the chair with safety restraint if ordered.			
21.	Make the patient comfortable. Place call light within reach.			
22.	Store lift properly until time to transfer patient again.			
23.	Wash your hands.			
24.	Report anything unusual to the charge nurse.			
Transferring Patient From Chair to Bed Using a Mechanical Lift				
1.	Ask for assistance from another health care assistant.			
2.	Wash your hands.			
3.	Assemble equipment.			

Transferring Patient From Chair to Bed Using a Mechanical Lift Cont.		Yes	No	Comments
4.	Identify and greet patient. Identify self and other health care assistant.			
5.	Explain what you are going to do.			
6.	Provide privacy. Pull curtain around bed.			
7.	Adjust bed height to low position. Lock brakes of bed.			
8.	Position chair next to bed with the back of chair in line with the headboard of the bed.			
9.	Wheel the lift into place over the patient with the base beneath the chair. Lock the wheels of the lift.			
10.	Put the hooks through the metal frame of the sling, which is still under the patient. **NOTE:** Be sure to apply hooks with open, sharp ends away from the patient.			
11.	Have the patient fold both arms across chest if possible.			
12.	Using the crank, lift the patient until the buttocks are clear of the chair. Make sure the patient is aligned in the sling and is securely suspended in a sitting position with legs dangling over the bottom of the sling.			
13.	Have your partner, a second heath care assistant, stand behind the chair and guide the patient's body over the side of the chair; release brakes on mechanical lift.			
14.	Move the lift away from the chair. Turn the patient in the sling toward the bed with the second health care assistant guiding the patient's body.			
15.	Open the support legs of the lift with the control lever, then bring the lift into position so that the patient is over the center of the bed. Lock the wheels on the lift.			
16.	Release the control knob slowly so that the patient will gradually be lowered onto the bed.			
17.	Remove the hooks from the frame of the lift.			
18.	Unlock wheels on lift. Move the lift away from the bed.			
19.	Remove the sling from under the patient by having him turn from side to side on the bed.			
20.	Put a pillow under the patient's head. Remake the top of the bed.			
21.	Make the patient comfortable. Place call light within patient's reach.			
22.	Pull up side rails if appropriate and lower bed to its lowest position.			
23.	Open curtain.			
24.	Wash your hands.			
25.	Record observations and report anything unusual to the charge nurse.			

Student's Signature/Date

Instructor's Signature/Date

Temperature

Unit Objective

After completing this unit you should be able to measure body temperature using a glass thermometer and a battery-operated electronic thermometer.

Specific Objectives

After completing this unit, you should be able to:

A. Match terms in this unit with their correct definitions.

B. Read a Fahrenheit thermometer.

C. Read a Centigrade thermometer.

D. Take an oral temperature using a glass oral thermometer according to steps of procedure.

E. Take an oral temperature using a battery-operated electronic thermometer according to steps of procedure.

F. Take a rectal temperature using a glass rectal thermometer according to steps of procedure.

G. Take a rectal temperature using a battery-operated electronic thermometer according to steps of procedure.

H. Take an axillary temperature using a glass oral thermometer according to steps of procedure.

I. Take an axillary temperature using a battery-operated electronic thermometer according to steps of procedure.

Introduction

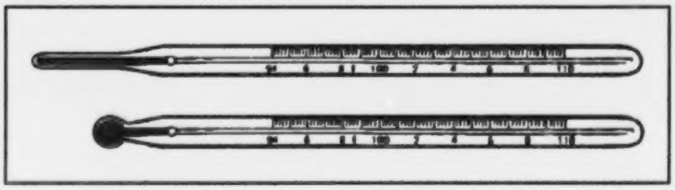
Body temperature is a measurement of heat in the body. Body temperature is measured with a thermometer. The thermometer is marked with lines and numbers for measuring body temperature. If it is an electronic thermometer, which is battery operated, it shows the temperature on a small screen. Many institutions use this type of thermometer, which has rectal and oral attachments.

There are two kinds of glass thermometers. An oral thermometer, usually coded blue, is used to take a patient's temperature by mouth. A rectal thermometer, usually coded red, is used to take a patient's temperature in the rectum. The newest type of thermometer is an aural or ear thermometer.

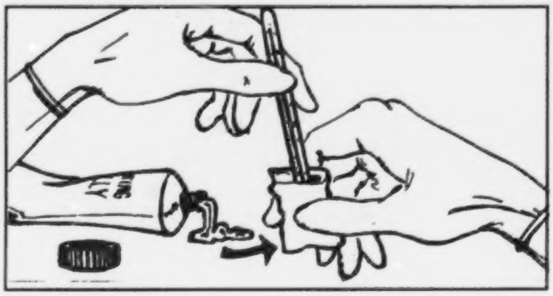
In this unit, you will learn to measure body temperature by using and reading different types of thermometers according to steps of procedure.

A. Terms

Glass thermometer - device used to measure body temperature in either Centigrade or Fahrenheit; there are two types: oral and rectal



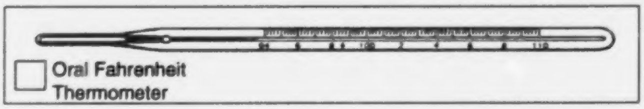
Lubricating jelly - substance used to make insertion of a rectal thermometer easier



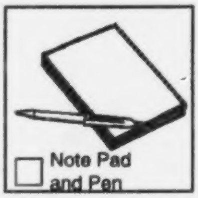
Axillary (axilla) temperature - temperature measured from a patient's armpit.

B. Steps of Procedure for Reading an Oral Fahrenheit Thermometer

1. Assemble equipment.



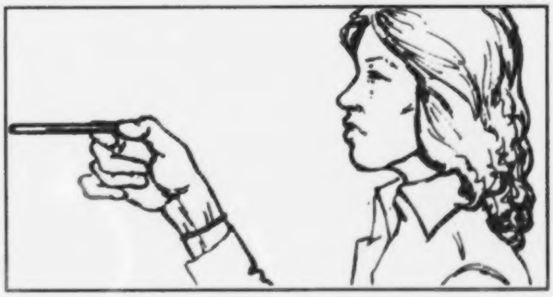
☐ Oral Fahrenheit Thermometer



☐ Note Pad and Pen

2. Hold the thermometer at the stem and at eye level.

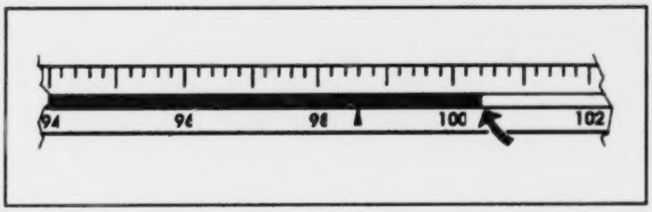
NOTE: Never hold the thermometer at the bulb end, the end with mercury.



3. Turn thermometer back and forth until you can see the mercury.

NOTE: Each long line marked on the thermometer stands for one degree. The four short lines between each long line equal two tenths (.2) of a degree. The small arrow at 98.6°F indicates the normal oral temperature of a young adult.

4. Find the end of the mercury and record the number.



Example: If the mercury ends after the 100 line, but on the second short line, the temperature is 100.4°F.

5. Write temperature on paper.

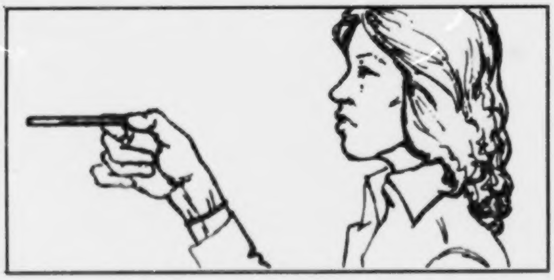
C. Steps of Procedure for Reading an Oral Centigrade Thermometer

1. Assemble equipment.

☐ Oral Centigrade Thermometer

2. Hold the thermometer at the stem and at eye level.

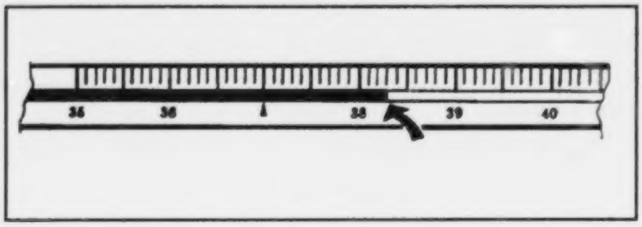
NOTE: Never hold the thermometer at the bulb, end with the mercury.



4. Check to see which type of Centigrade thermometer you are using. Do the short lines equal 1/10 (.1) or 2/10 (.2)?

NOTE: Long lines on the thermometer equal one degree. The short lines between each of the long lines equal 1/10 (.1) or 2/10 (.2) of a degree depending on the type of thermometer. 37°C equals 98.6°F.

5. Read the line or number where the mercury ends.



EXAMPLE: If the thermometer is in 1/10 increments and the mercury ends after the 38 line, but on the third short line, the temperature is 38.3°C.

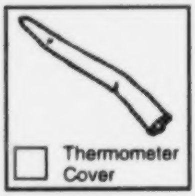
NOTE: If the Centigrade thermometer has short lines equal to 2/10 then it would be similar to Fahrenheit markings. For example, if the mercury ends after the 39 line, but on the second short line, the temperature is 39.4°C.

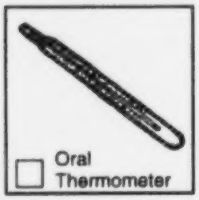
6. Write temperature on paper.

D. Steps of Procedure for Taking Oral Temperature Using a Glass Oral Thermometer

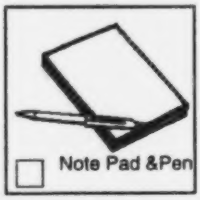
1. Wash your hands. Put on gloves.

2. Assemble equipment.


☐ Thermometer Cover


☐ Oral Thermometer

☐ Tissue


☐ Note Pad &Pen

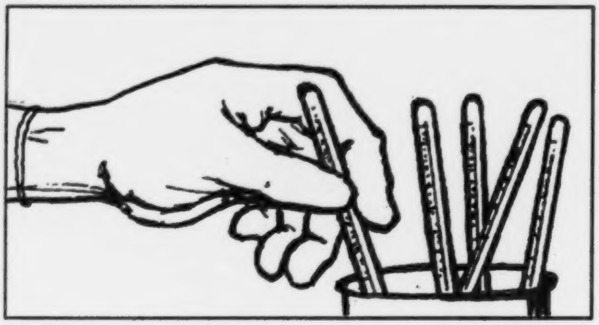
3. Identify and greet patient. Identify self.

4. Explain what you are going to do.

5. Provide privacy. Pull curtain around bed.

6. Patient should be in sitting or lying down position. Lower side rail.

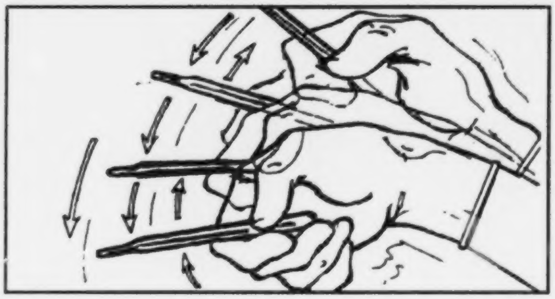
7. Take thermometer from its container. Rinse thermometer with cool water if it has been soaked in disinfectant solution, then dry it.



8. Check thermometer for breaks or chips.

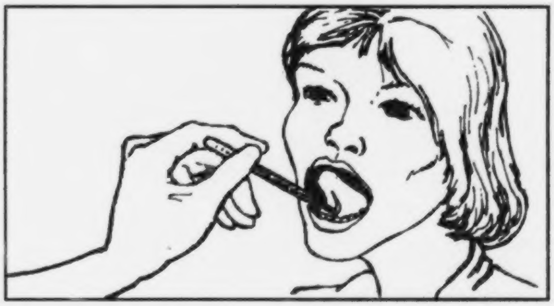
9. Shake down thermometer to 94°F or below by firmly grasping at the stem end and snapping your wrist several times. Put cover on thermometer if used in your facility.

CAUTION: Stand away from all objects, so you will not hit the thermometer on something and break it.

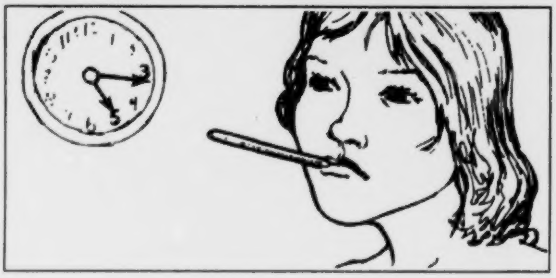


10. Ask patient to open mouth and raise tongue. Place the thermometer bulb under patient's tongue toward side of mouth.

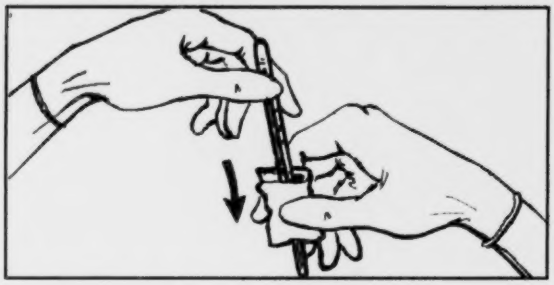
NOTE: Oral thermometers should never be used for unconscious or confused patients. Be sure patient is awake and alert before putting a thermometer in patient's mouth. Patients receiving oxygen should not have temperature taken orally. If the patient has been smoking, chewing gum, or consumed a hot/cold beverage, wait 30 minutes before taking oral temperature.



11. Instruct the patient to hold the thermometer in place by closing her lips around the thermometer, while holding bulb under tongue. Leave in place for at least five minutes.

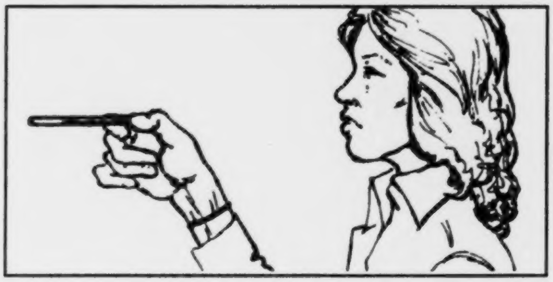


12. Remove the thermometer. Remove plastic cover. If cover was not used, use tissue to wipe thermometer clean from the stem to the bulb.

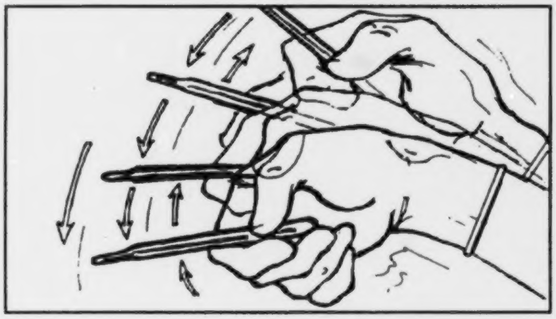


13. Read the thermometer.

14. Record the temperature reading on the paper or notepad.



15. Shake down the thermometer.



16. Remove, clean, and store equipment.

17. Remove gloves and dispose in appropriate container. Wash hands.

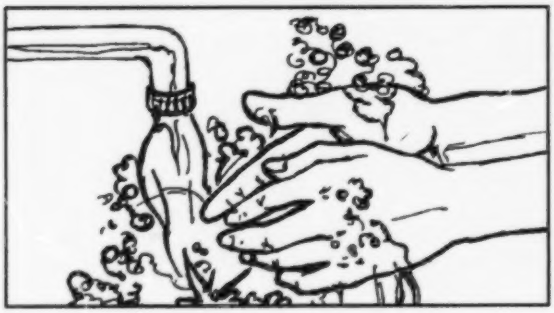
18. Make the patient comfortable. Put call light within reach. Pull up side rails if appropriate.

19. Record temperature on appropriate form and report anything unusual to the charge nurse.

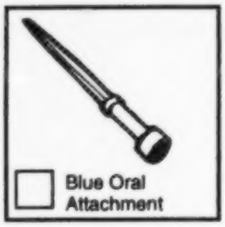
NOTE: For the elderly, the average oral temperature is 96.8 but may be as low as 95°F.

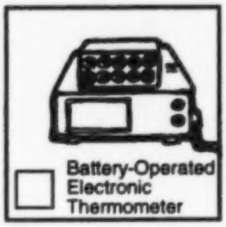
E. Steps of Procedure for Taking Oral Temperature Using a Battery-Operated Electronic Oral Thermometer

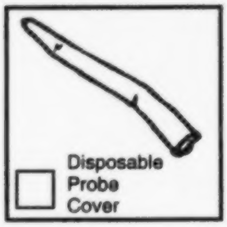
1. Wash your hands. Put on gloves.

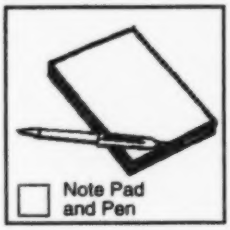


2. Assemble equipment.


☐ Blue Oral Attachment


☐ Battery-Operated Electronic Thermometer


☐ Disposable Probe Cover


☐ Note Pad and Pen

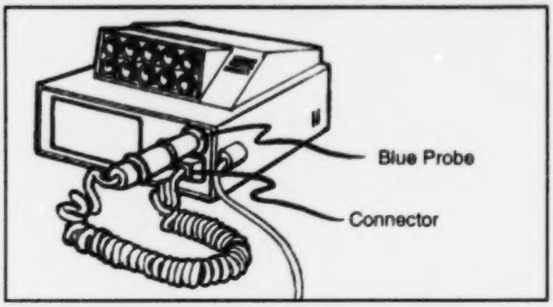
3. Identify and greet patient. Identify self.

4. Explain what you are going to do.

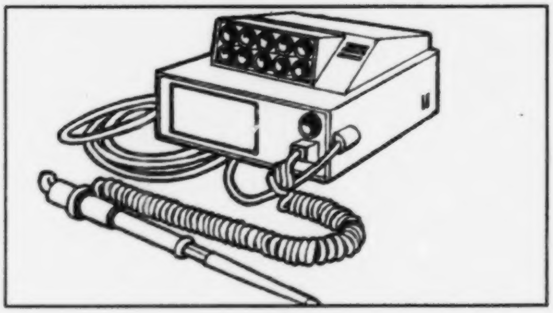
5. Provide privacy. Pull curtain around bed.

6. Patient should be in sitting or lying down position. Lower side rail.

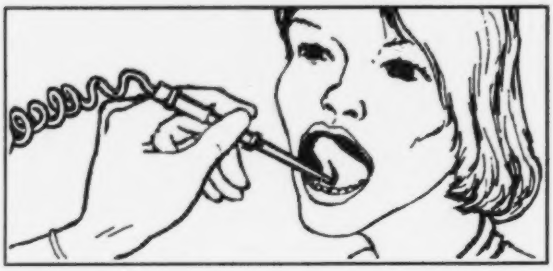
7. Make sure oral probe is plugged into the thermometer tightly and that probe is blue.



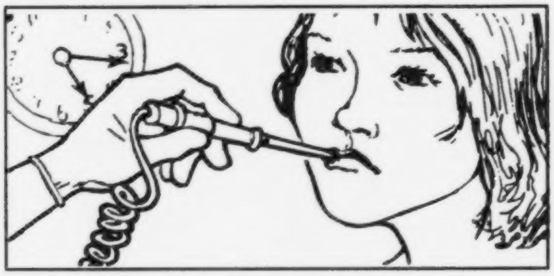
8. Remove the probe from the unit and insert it into a probe cover.



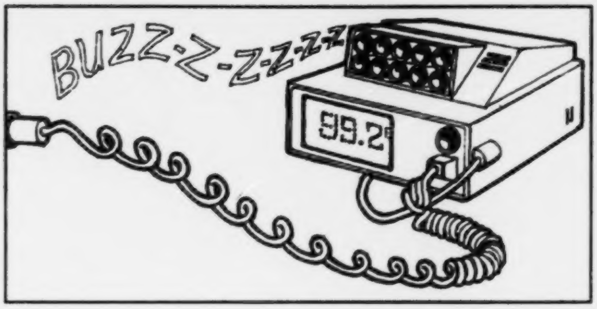
9. Ask patient to open the mouth and raise the tongue; place covered probe at the base of the tongue on either side.



10. Ask the patient to lower the tongue and close the mouth tightly.



11. Hold the probe in the patient's mouth until the tone is heard or when there is a flashing or steady light.



12. Read the temperature reading on the digital display.

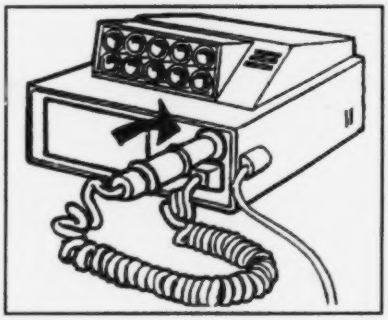
13. Remove the covered probe from the patient's mouth and discard the probe cover by pressing the eject button. Do not touch probe tip.

14. Record the temperature reading on paper or notepad.

15. Return the probe to the holder.

NOTE: Record temperature before returning probe to its stored position. When you return probe, the reading automatically disappears.

NOTE: Store thermometer in its stand when not in use. Battery gets recharged in this stand.



16. Remove, clean, and store equipment.

17. Remove gloves and dispose in appropriate container. Wash hands.

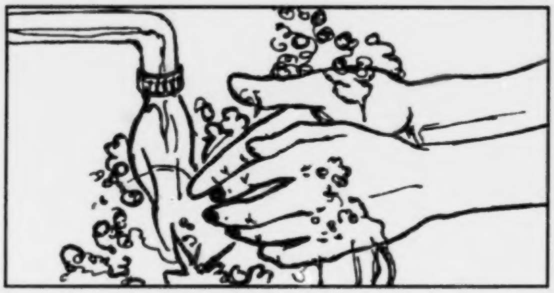
18. Make the patient comfortable; place call light within reach. Pull up side rails if appropriate.

19. Record temperature on appropriate form and report anything unusual to the charge nurse.

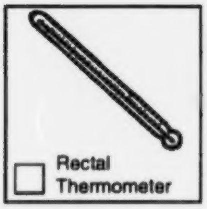
NOTE: For the elderly, the average oral temperature is 96.8 but may be as low as 95°F.

F. Steps of Procedure for Taking Rectal Temperature Using Glass Rectal Thermometer

1. Wash your hands. Put on gloves.

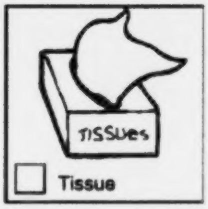


2. Assemble equipment.

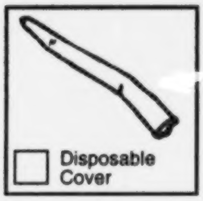


☐ Rectal Thermometer

☐ Lubricating Jelly

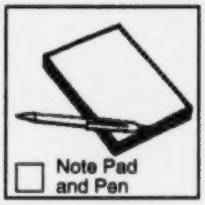


☐ Tissue



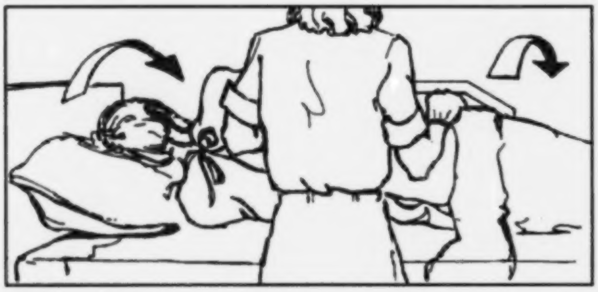
☐ Disposable Cover

☐ Toilet Paper

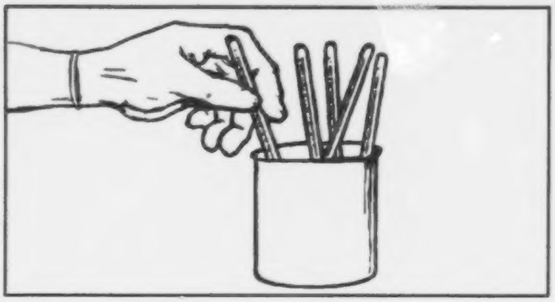


☐ Note Pad and Pen

3. Identify and greet patient. Identify self.
4. Explain what you are going to do.
5. Provide privacy. Pull curtain around bed.
6. Instruct/assist patient to lie on his side with upper leg flexed (bent). Lower side rail.

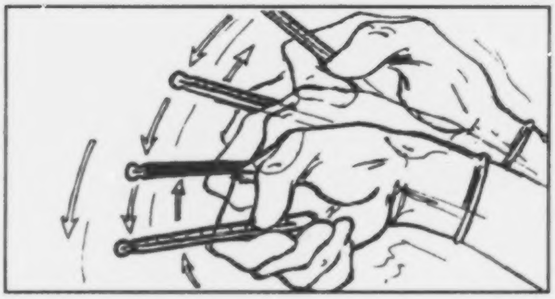


7. Take thermometer from its container. Rinse thermometer with cool water if it has been soaked in disinfectant solution, then dry it.

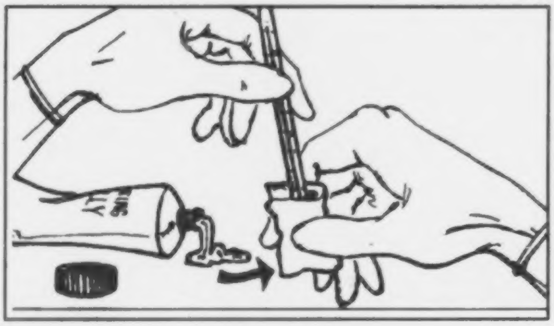


8. Check thermometer for breaks or chips.

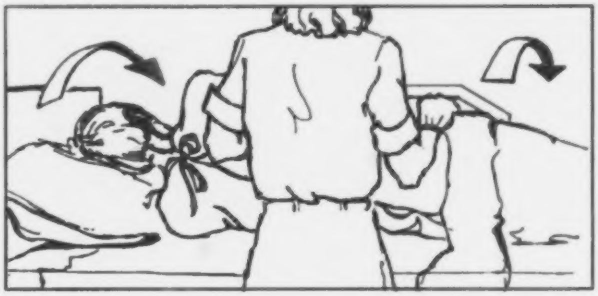
9. Shake down thermometer to 94°F or below by firmly grasping the stem end and snapping your wrist several times. Put cover on thermometer if used in your facility.



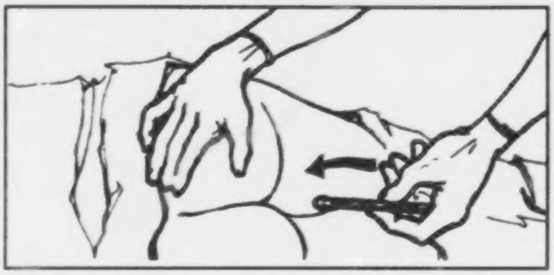
10. Put a small amount of lubricant on a tissue and lubricate the bulb end of the thermometer. If using a cover, lubricate it.



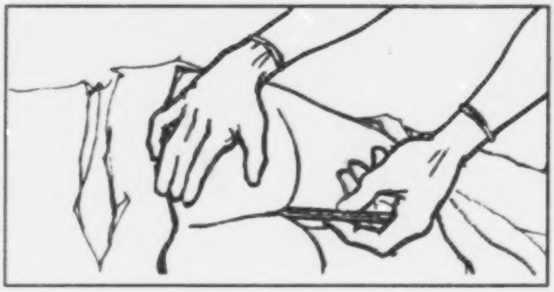
11. Pull back covers and patient's gown just enough to see patient's buttocks. Do not overexpose patient.



12. Raise the upper buttock to expose the anus; insert bulb end of the thermometer one inch into the rectum. Cover patient.

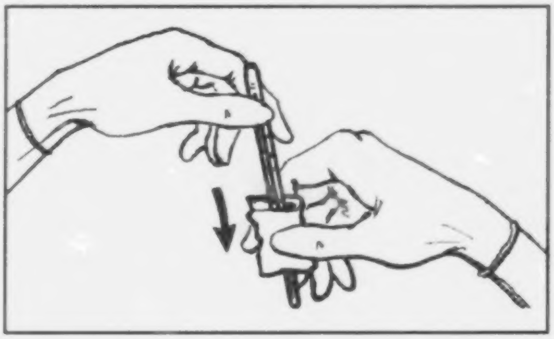


13. Hold the thermometer in place for three to four minutes while holding top hip of patient to prevent rolling back. Do not leave a patient alone with a rectal thermometer inserted.



NOTE: Rectal temperature should not be taken if patient has diarrhea or if patient has a rectal disorder, an injury, or has recently had rectal surgery.

14. Remove the thermometer. Remove plastic cover. If cover was not used, use tissue to wipe thermometer clean from the stem toward the bulb.

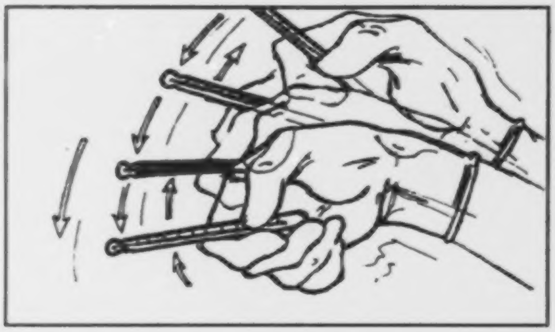


15. Place the thermometer on clean toilet paper, wipe the anal area with toilet paper to remove excess lubricant.

16. Cover the patient.

17. Read the thermometer and record temperature reading on paper or notepad. Note that it is a rectal temperature. Example: 100°R.

18. Shake down the thermometer and return to its container.



19. Remove, clean, and store equipment.

20. Remove gloves and dispose in appropriate container. Wash hands.

21. Make the patient comfortable; place call light within reach.

22. Pull up side rails if appropriate.

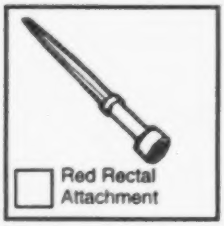
23. Record temperature on appropriate form and note that it is rectal. Report anything unusual to the charge nurse.

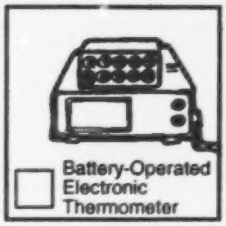
NOTE: For the elderly, the average rectal temperature is 97.8 but may be as low as 96°F.

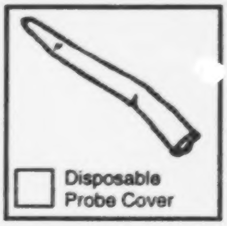
G. Steps of Procedure for Taking Rectal Temperature Using a Battery-Operated Electronic Rectal Thermometer

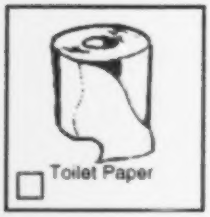
1. Wash your hands. Put on gloves.

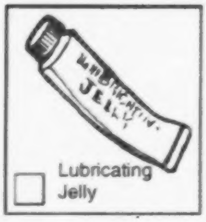
2. Assemble equipment.

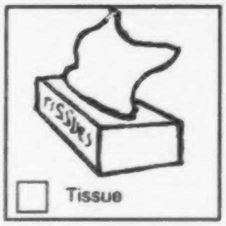

☐ Red Rectal Attachment

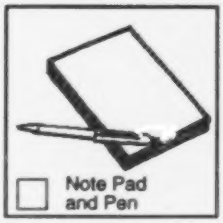

☐ Battery-Operated Electronic Thermometer


☐ Disposable Probe Cover


☐ Toilet Paper


JELLY
☐ Lubricating Jelly


TISSUES
☐ Tissue

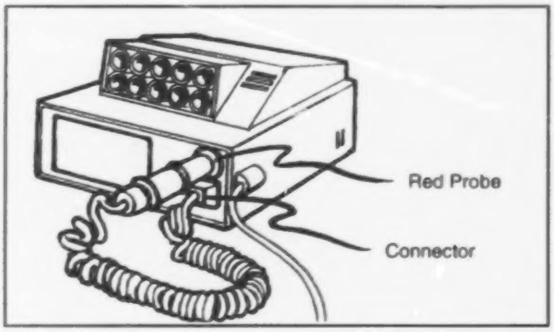

☐ Note Pad and Pen

3. Identify and greet patient. Identify self.

4. Explain what you are going to do.

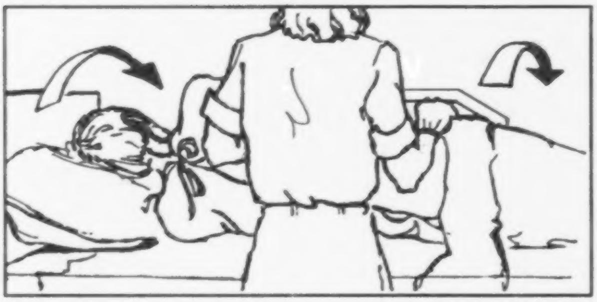
5. Provide privacy. Pull curtain around bed.

6. Check to be sure that the probe connector is plugged in tightly and that probe is red.

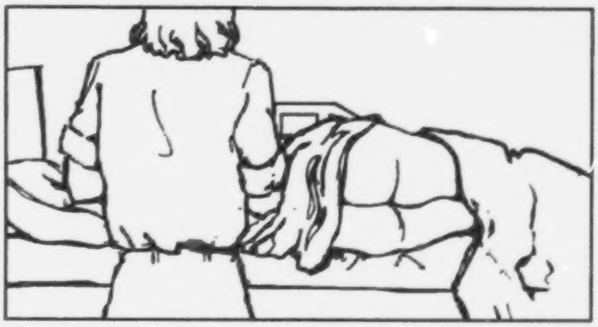

Red Probe
Connector

7. Lower side rail.

8. Have patient turn on side or turn patient yourself with upper leg flexed (bent).

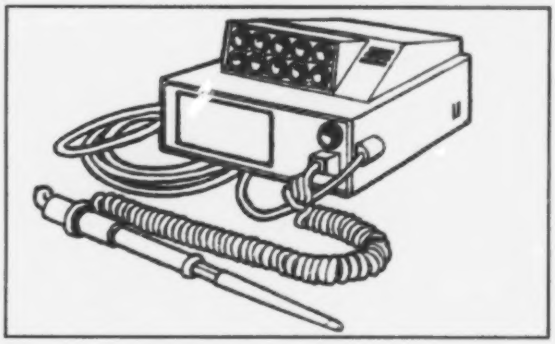


9. Pull back covers and patient's gown just enough to see patient's buttocks. Do not overexpose patient.



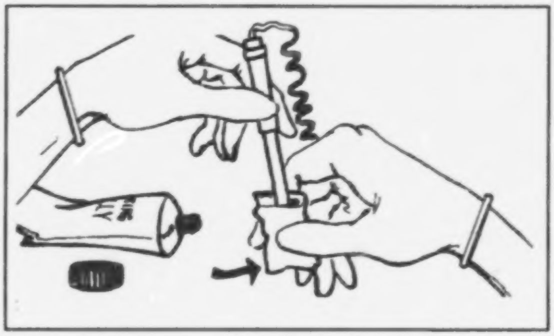
NOTE: Rectal temperature should not be taken if patient has diarrhea or if patient has a rectal disorder, injury or has recently had rectal surgery.

10. Remove probe from its stored position.

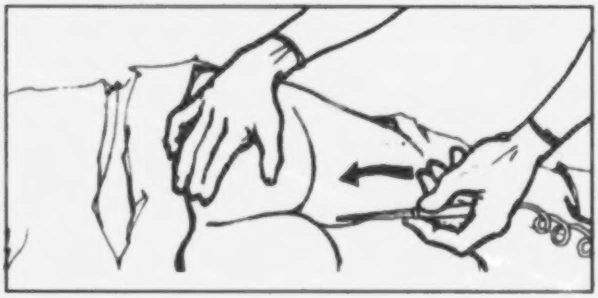


11. Insert probe into probe cover.

12. Put a small amount of lubricating jelly on a piece of tissue. Lubricate the probe with lubricated tissue.



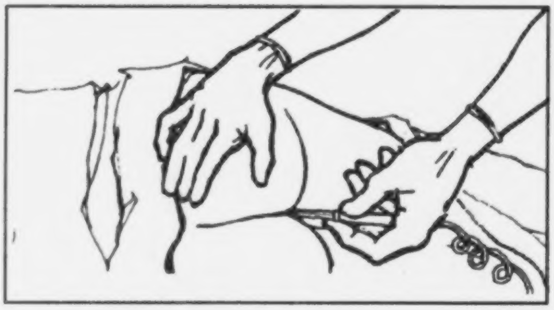
13. Raise upper buttock with one hand until you can see the anus (opening to the rectum).



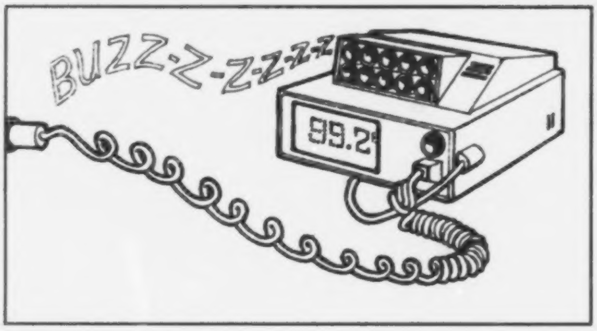
14. Gently insert probe one inch into the rectum. Cover patient.

CAUTION: Never push thermometer too far or too hard, as you may injure the rectum.

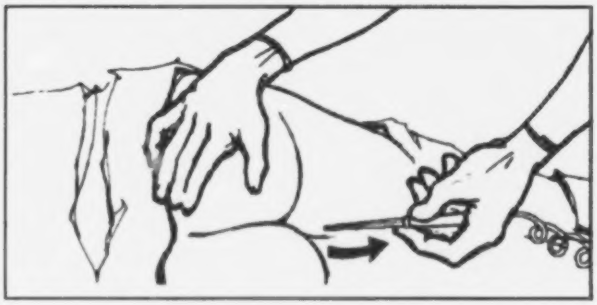
15. Hold probe in place. Keep your hand on the patient's hip to prevent patient from rolling back. Do not leave a patient alone with a rectal probe inserted.



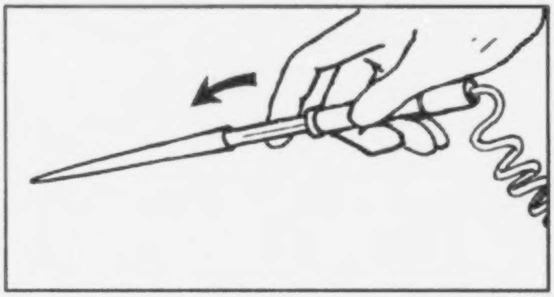
16. Hold probe until the buzzer sounds or there is a flashing or steady light, then observe patient's temperature on the screen.



17. Gently remove probe from patient's rectum.



18. Remove probe cover by ejecting it into trash can. Do not touch probe tip.



19. Record temperature on paper or notepad. Note that it is a rectal temperature. Example: 100°R.

NOTE: Record temperature before returning probe to its stored position. When you return probe, the reading automatically disappears.

20. Return the probe to the holder.

NOTE: Store thermometer in its stand when not in use. Battery gets recharged in this stand.

21. Wipe the anal area with tissue to remove excess lubricant. Cover the patient.

22. Make the patient comfortable. Place call light within reach. Pull up side rails if appropriate.

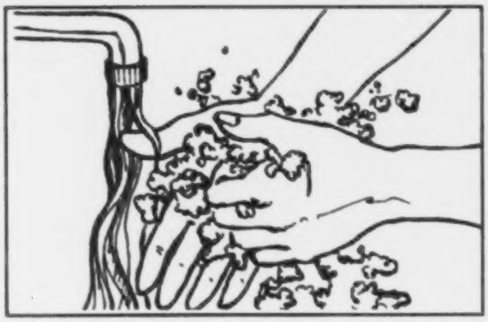
23. Remove gloves and discard them in appropriate container. Wash your hands.

24. Record temperature on appropriate form and report anything unusual to the charge nurse.

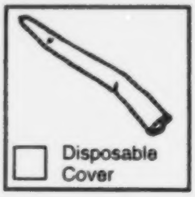
NOTE: For the elderly, the average rectal temperature is 97.8 but may be as low as 96°F.

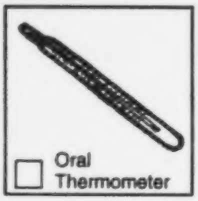
H. Steps of Procedure for Taking Axillary Temperature Using Glass Oral Thermometer

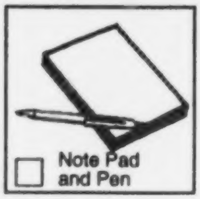
1. Wash your hands.



2. Assemble equipment.


☐ Disposable Cover


☐ Oral Thermometer

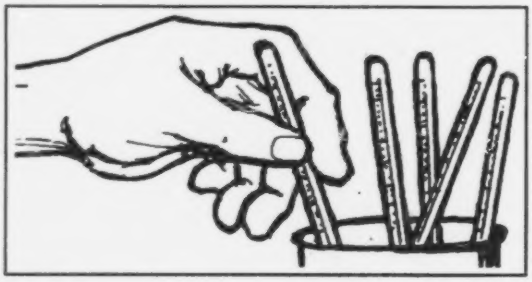

☐ Note Pad and Pen

3. Identify and greet patient. Identify self.

4. Explain what you are going to do.

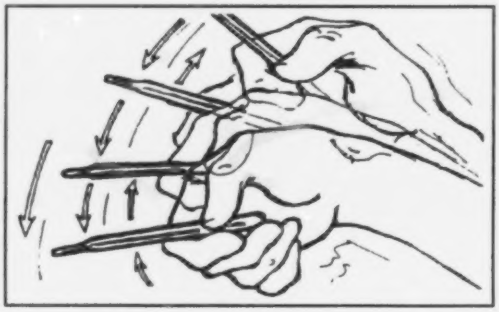
5. Provide privacy. Pull curtain around bed.

6. Take thermometer from its container. Rinse thermometer with cool water if it has been soaked in disinfectant solution, then dry it.

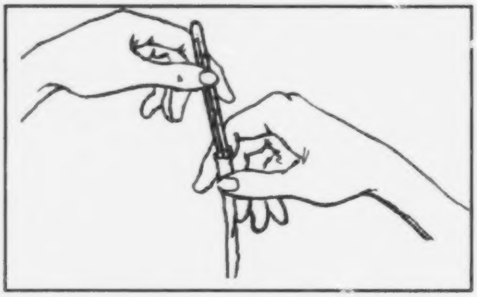


7. Check thermometer for breaks or chips.

8. Shake down thermometer to 94°F or below; firmly grasp at the stem end and snap your wrist several times.



9. Put cover on thermometer if used in your facility.



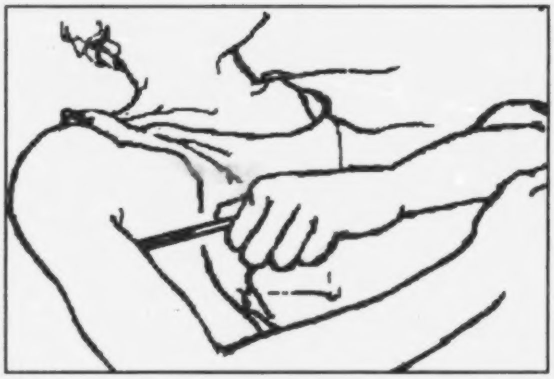
10. Instruct/assist patient to assume sitting or supine position. Lower side rail.

11. Help the patient remove an arm from the sleeve of the gown without exposing the patient.

12. Using a towel, dry axilla (armpit) of excessive perspiration.

13. Place bulb (mercury) end of thermometer in the center of patient's armpit.

14. Bring the arm across the chest and hold arm to snugly hold the thermometer in place for 10 to 12 minutes.

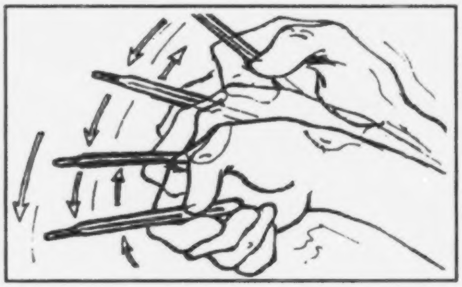


15. Lift arm and remove thermometer. Remove cover. If cover was not used, use tissue to wipe thermometer clean from the stem toward the bulb.

NOTE: Do not pull thermometer out before lifting arm.

16. Read and record temperature reading. Note that it is an axillary temperature. Example: 95.8°A.

17. Shake down the thermometer and return to its container.



18. Remove, clean, and store equipment. Put towel with dirty linen.

19. Wash your hands.

20. Place patient's arm back in sleeve of gown.

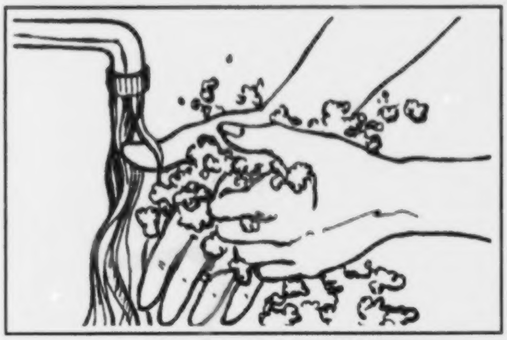
21. Make the patient comfortable; place call signal within reach. Raise side rails if appropriate.

22. Record temperature on appropriate form and note that it is an axillary temperature, example 99.2°A. Report anything unusual to the charge nurse.

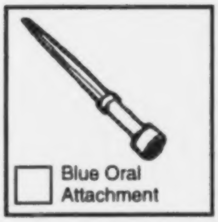
NOTE: For the elderly, the average axillary temperature is 95.5, but may be as low as 94°F.

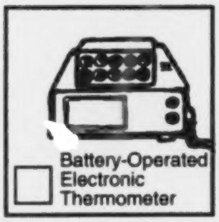
I. Steps of Procedure for Taking Axillary Temperature Using a Battery-Operated Electronic Oral Thermometer

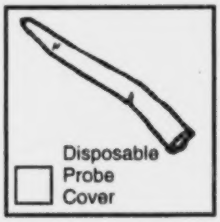
1. Wash your hands.

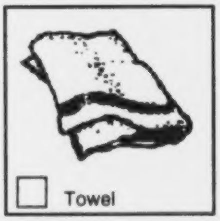


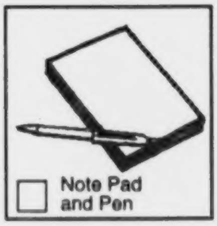
2. Assemble equipment.


☐ Blue Oral Attachment


☐ Battery-Operated Electronic Thermometer


☐ Disposable Probe Cover

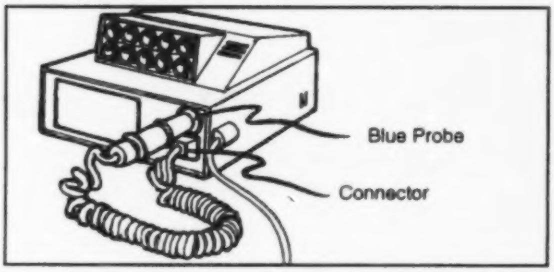

☐ Towel


☐ Note Pad and Pen

3. Identify and greet patient. Identify self.

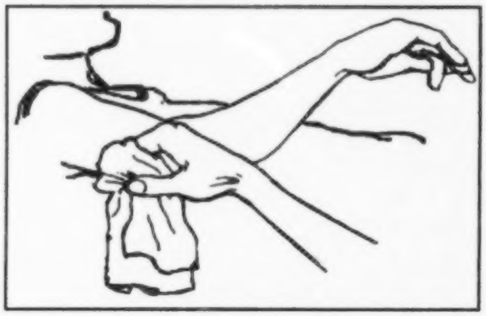
4. Explain what you are going to do.

5. Check to be sure that the probe connector is plugged in tightly and that probe is blue.

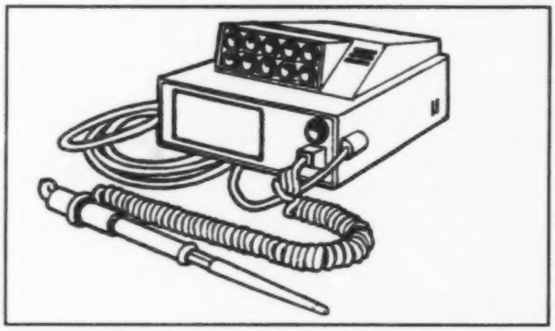


6. Provide privacy. Pull curtain around bed.

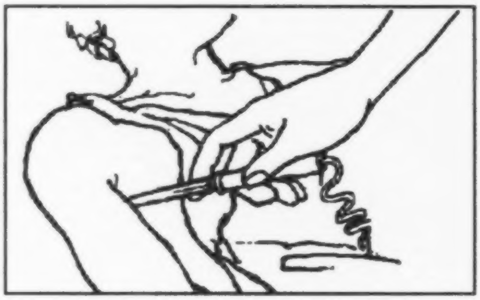
7. Lower side rail. Remove the patient's arm from the sleeve of his gown. Dry the underarm with a towel.



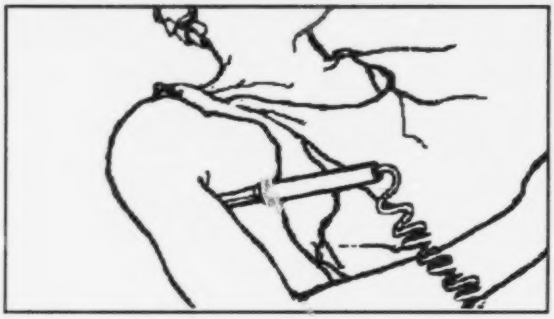
8. Remove probe from its stored position. Insert probe into probe cover.



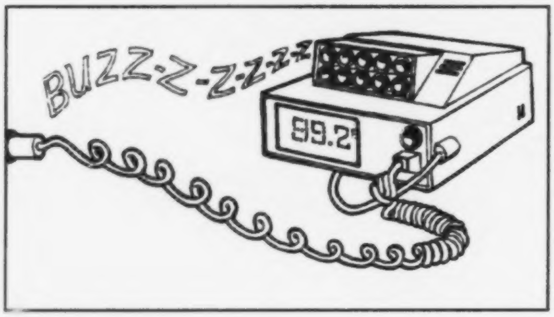
9. Put the covered probe in the center of the patient's armpit (axilla).



10. Put the patient's arm across his chest. Hold the probe in place.



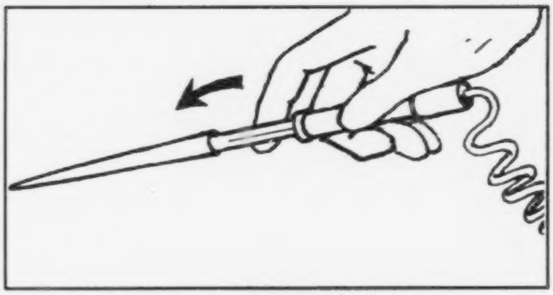
11. Hold probe until the buzzer sounds or there is a flashing or steady light, then observe patient's temperature on the screen. Lift patient's arm and remove the probe from the patient's armpit.



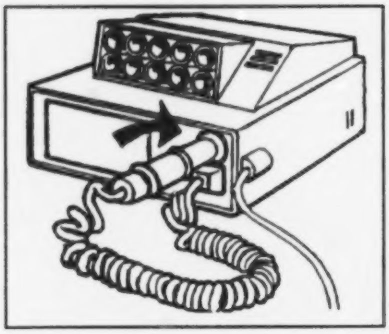
12. Record temperature on paper or notepad. Note that it is axillary. Example. 95.8°A.

NOTE: Record temperature before returning probe to its stored position. When you return probe, the reading automatically disappears.

13. Discard used probe cover by ejecting it into trash can. Do not touch probe tip.



14. Return the probe to the holder.



NOTE: Store the thermometer in its charging stand when not in use. Battery gets recharged in this stand.

15. Put patient's arm back into sleeve of gown.

16. Remove, clean, and store equipment. Put towel with dirty linen.

17. Wash your hands.

18. Make the patient comfortable. Place call light within reach. Raise side rails if appropriate.

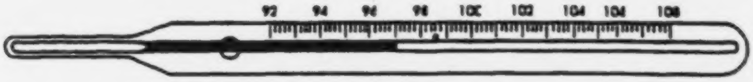
19. Record temperature on appropriate form and note that it is an axillary temperature. Report anything unusual to the charge nurse.

NOTE: For the elderly, the average axillary temperature is 95.5, but may be as low as 94°F.

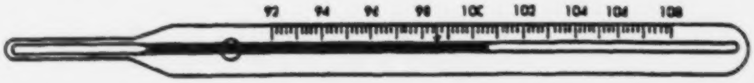
Temperature
Skill Sheet 1

Directions: Read each of the following thermometers an write down the temperature it shows in the blank space beside it. Be sure to put Centigrade or Fahrenheit.

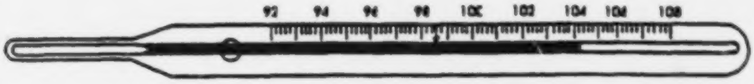
1. ____________


92
94
96
98
100
102
104
106
108

2. ____________

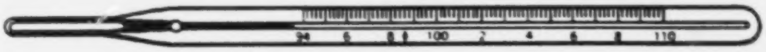

92
94
96
98
100
102
104
106
108

3. ____________

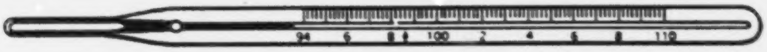

92
94
96
98
100
102
104
106
108

Look at the temperature readings beside each thermometer below. Use an arrow or line to mark the temperature on the thermometer.

4. 98.6°


94
6
8
100
2
4
6
8
110

5. 99.2°


94
6
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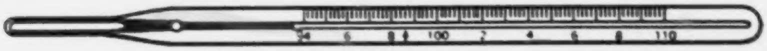
6
8
110

6. 101.8°


94
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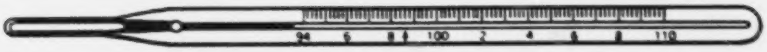
4
6
8
110

7. 103°

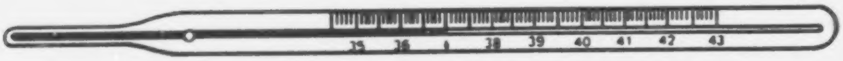

94
6
8
100
2
4
6
8
110

Temperature

Skill Sheet 2

Directions: Read each of the folowing thermometers and record the temperature it shows in the blank space beside it. Be sure to put Centigrade or Fahrenheit.

1. ____________


35
36
38
39
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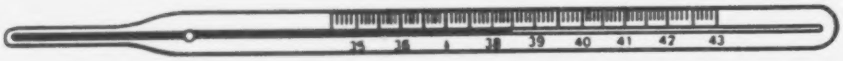
42
43

2. ____________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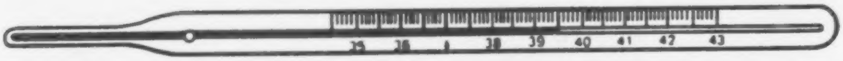
42
43

3. ____________


35
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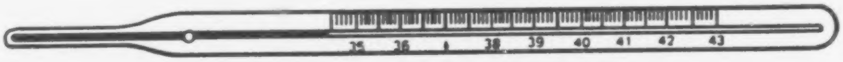
43

Look at the temperature readings beside each thermometer below. Use an arrow or line to mark the temperature on the thermometer.

4. 37°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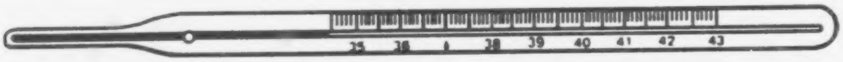
5. 39°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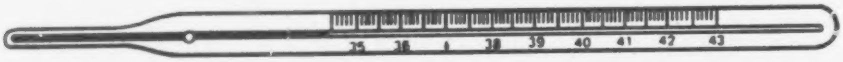
6. 37.5°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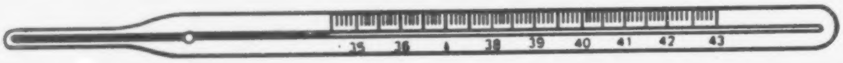
43

7. 36.9°


35
36
38
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42
43

Temperature
Written Evaluation

Circle the letter that corresponds to the best answer.

1. Where is an oral thermometer placed when taking a patient's oral temperature?

   a. It is placed in the patient's mouth.
   b. It is placed under the patient's arm.
   c. It is placed in the patient's rectum.
   d. It is placed in the patient's ear.

2. Which of the following rectal temperatures would you be sure to report to your supervisor as being too high?

   a. 98.6°F (37°C)
   b. 102°F (38.9°C)
   c. 99°F (37.2°C)
   d. 96°F (35.6°C)

3. Where is a rectal thermometer placed when taking a patient's temperature?

   a. It is placed in the patient's rectum.
   b. It is placed under the patient's arm.
   c. It is placed in the patient's ear.
   d. It is placed in the patient's mouth.

4. An axillary temperature is taken with a glass oral thermometer for:

   a. 5-8 minutes.
   b. 10-12 minutes.
   c. 3-4 minutes.
   d. 1-2 minutes.

Match the terms in Column A with the definitions in Column B.

Column A

_____ 5. Lubricating jelly

_____ 6. Axillary (axilla) temperature

_____ 7. Glass thermometer

Column B

a. Temperature measured from a patient's rectum
b. Substance used to perform a backrub
c. Temperature measured from a patient's ear
d. Device used to measure body temperature in either Centigrade or Fahrenheit; there are two types, oral and rectal
e. Temperature measured from a patient's armpit
f. Substance used to make insertion of a rectal thermometer easier

Temperature
Evaluation

________________________ has successfully performed the following steps of procedure.
(Student)

Reading an Oral Fahrenheit Thermometer		Yes	No	Comments
1.	Assemble equipment.			
2.	Hold the thermometer at the stem and at eye level. **NOTE**: Never hold the thermometer at the bulb end, the end with mercury.			
3.	Turn thermometer back and forth until you can see the mercury. **NOTE**: Each long line marked on the thermometer stands for one degree. The four short lines between each long line equal two tenths (.2) of a degree. The small arrow at 98.6°F indicates the normal oral temperature of a young adult.			
4.	Find the end of the mercury and record the number. **Example**: If the mercury ends after the 100 line, but on the second short line, the temperature is 100.4°F.			
5.	Write temperature on paper.			
Reading an Oral Centigrade Thermometer				
1.	Assemble equipment.			
2.	Hold the thermometer at the stem and at eye level. **NOTE**: Never hold the thermometer at the bulb, end with the mercury.			
3.	Turn the thermometer back and forth until you can see the mercury column.			
4.	Check to see which type of Centigrade thermometer you are using. Do the short lines equal 1/10 (.1) or 2/10 (.2)? **NOTE**: Long lines on the thermometer equal one degree. The short lines between each of the long lines equal 1/10 (.1) or 2/10 (.2) of a degree depending on the type of thermometer. 37°C equals 98.6°F.			
5.	Read the line or number where the mercury ends. **EXAMPLE**: If the thermometer is in 1/10 increments and the mercury ends after the 38 line, but on the third short line, the temperature is 38.3°C. **NOTE:** If the Centigrade thermometer has short lines equal to 2/10 then it would be similar to Fahrenheit markings. For example, if the mercury ends after the 39 line, but on the second short line, the temperature is 39.4°C.			
6.	Write temperature on paper.			
Taking Oral Temperature Using a Glass Oral Thermometer				
1.	Wash your hands. Put on gloves.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			

Takig Oral Temperature Using a Glass Oral Thermometer Cont.		**Yes**	**No**	**Comments**
4.	Explain what you are going to do.			
5.	Provide privacy. Pull curtain around bed.			
6.	Patient should be in sitting or lying down position. Lower side rail.			
7.	Take thermometer from its container. Rinse thermometer with cool water if it has been soaked in disinfectant solution, then dry it.			
8.	Check thermometer for breaks or chips.			
9.	Shake down thermometer to 94°F or below by firmly grasping at the stem end and snapping your wrist several times. Put cover on thermometer if used in your facility. **CAUTION:** Stand away from all objects, so you will not hit the thermometer on something and break it.			
10.	Ask patient to open mouth and raise tongue. Place the thermometer bulb under patient's tongue toward side of mouth. **NOTE:** Oral thermometers should never be used for unconscious or confused patients. Be sure patient is awake and alert before putting a thermometer in patient's mouth. Patients receiving oxygen should not have temperature taken orally. If the patient has been smoking, chewing gum, or consumed a hot/cold beverage, wait 30 minutes before taking oral temperature.			
11.	Instruct the patient to hold the thermometer in place by closing her lips around the thermometer, while holding bulb under tongue. Leave in place for at least five minutes.			
12.	Remove the thermometer. Remove plastic cover. If cover was not used, use tissue to wipe thermometer clean from the stem to the bulb.			
13.	Read the thermometer.			
14.	Record the temperature reading on the paper or notepad.			
15.	Shake down the thermometer.			
16.	Remove, clean, and store equipment.			
17.	Remove gloves and dispose in appropriate container. Wash hands.			
18.	Make the patient comfortable. Put call light within reach. Pull up side rails if appropriate.			
19.	Record temperature on appropriate form and report anything unusual to the charge nurse. **NOTE:** For the elderly, the average oral temperature is 96.8 but may be as low as 95°F.			
Taking Oral Temperature Using a Battery-Operated Electronic Oral Thermometer				
1.	Wash your hands. Put on gloves.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			

Taking Oral Temperature Using a Battery-Operated Electronic Oral Thermometer Cont.		**Yes**	**No**	**Comments**
5.	Provide privacy. Pull curtain around bed.			
6.	Patient should be in sitting or lying down position. Lower side rail.			
7.	Make sure oral probe is plugged into the thermometer tightly and that probe is blue.			
8.	Remove the probe from the unit and insert it into a probe cover.			
9.	Ask patient to open the mouth and raise the tongue; place covered probe at the base of the tongue on either side.			
10.	Ask the patient to lower the tongue and close the mouth tightly.			
11.	Hold the probe in the patient's mouth until the tone is heard or when there is a flashing or steady light.			
12.	Read the temperature reading on the digital display.			
13.	Remove the covered probe from the patient's mouth and discard the probe cover by pressing the eject button. Do not touch probe tip.			
14.	Record the temperature reading on paper or notepad.			
15.	Return the probe to the holder. **NOTE:** Record temperature before returning probe to its stored position. When you return probe, the reading automatically disappears. **NOTE:** Store thermometer in its stand when not in use. Battery gets recharged in this stand.			
16.	Remove, clean, and store equipment.			
17.	Remove gloves and dispose in appropriate container. Wash hands.			
18.	Make the patient comfortable; place call light within reach. Pull up side rails if appropriate.			
19.	Record temperature on appropriate form and report anything unusual to the charge nurse. **NOTE:** For the elderly, the average oral temperature is 96.8 but may be as low as 95°F.			
Taking Rectal Temperature Using Glass Rectal Thermometer				
1.	Wash your hands. Put on gloves.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Provide privacy. Pull curtain around bed.			
6.	Instruct/assist patient to lie on his side with upper leg flexed (bent). Lower side rail.			
7.	Take thermometer from its container. Rinse thermometer with cool water if it has been soaked in disinfectant solution, then dry it.			

Taking Rectal Temperature Using Glass Rectal Thermometer Cont.		Yes	No	Comments
8.	Check thermometer for breaks or chips.			
9.	Shake down thermometer to 94°F or below by firmly grasping the stem end and snapping your wrist several times. Put cover on thermometer if used in your facility.			
10.	Put a small amount of lubricant on a tissue and lubricate the bulb end of the thermometer. If using a cover, lubricate it.			
11.	Pull back covers and patient's gown just enough to see patient's buttocks. Do not overexpose patient.			
12.	Raise the upper buttock to expose the anus; insert bulb end of the thermometer one inch into the rectum. Cover patient.			
13.	Hold the thermometer in place for three to four minutes while holding top hip of patient to prevent rolling back. Do not leave a patient alone with a rectal thermometer inserted. **NOTE:** Rectal temperature should not be taken if patient has diarrhea or if patient has a rectal disorder, an injury, or has recently had rectal surgery.			
14.	Remove the thermometer. Remove plastic cover. If cover was not used, use tissue to wipe thermometer clean from the stem toward the bulb.			
15.	Place the thermometer on clean toilet paper, wipe the anal area with toilet paper to remove excess lubricant.			
16.	Cover the patient.			
17.	Read the thermometer and record temperature reading on paper or notepad. Note that it is a rectal temperature. Example: 100°R.			
18.	Shake down the thermometer and return to its container.			
19.	Remove, clean, and store equipment.			
20.	Remove gloves and dispose in appropriate container. Wash hands.			
21.	Make the patient comfortable; place call light within reach.			
22.	Pull up side rails if appropriate.			
23.	Record temperature on appropriate form and note that it is rectal. Report anything unusual to the charge nurse. **NOTE:** For the elderly, the average rectal temperature is 97.8 but may be as low as 96°F.			
Taking Rectal Temperature Using a Battery-Operated Electronic Rectal Thermometer				
1.	Wash your hands. Put on gloves.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Provide privacy. Pull curtain around bed.			

Taking Rectal Temperature Using a Battery-Operated Electronic Rectal Thermometer Cont.		**Yes**	**No**	**Comments**
6.	Check to be sure that the probe connector is plugged in tightly and that probe is red.			
7.	Lower side rail.			
8.	Have patient turn on side or turn patient yourself with upper leg flexed (bent).			
9.	Pull back covers and patient's gown just enough to see patient's buttocks. Do not overexpose patient. **NOTE:** Rectal temperature should not be taken if patient has diarrhea or if patient has a rectal disorder, injury or has recently had rectal surgery.			
10.	Remove probe from its stored position.			
11.	Insert probe into probe cover.			
12.	Put a small amount of lubricating jelly on a piece of tissue. Lubricate the probe with lubricated tissue.			
13.	Raise upper buttock with one hand until you can see the anus (opening to the rectum).			
14.	Gently insert probe one inch into the rectum. Cover patient. **CAUTION:** Never push thermometer too far or too hard, as you may injure the rectum.			
15.	Hold probe in place. Keep your hand on the patient's hip to prevent patient from rolling back. Do not leave a patient alone with a rectal probe inserted.			
16.	Hold probe until the buzzer sounds or there is a flashing or steady light, then observe patient's temperature on the screen.			
17.	Gently remove probe from patient's rectum.			
18.	Remove probe cover by ejecting it into trash can. Do not touch probe tip.			
19.	Record temperature on paper or notepad. Note that it is a rectal temperature. Example: 100°R. **NOTE:** Record temperature before returning probe to its stored position. When you return probe, the reading automatically disappears.			
20.	Return the probe to the holder. **NOTE:** Store thermometer in its stand when not in use. Battery gets recharged in this stand.			
21.	Wipe the anal area with tissue to remove excess lubricant. Cover the patient.			
22.	Make the patient comfortable. Place call light within reach. Pull up side rails if appropriate.			
23.	Remove gloves and discard them in appropriate container. Wash your hands.			
24.	Record temperature on appropriate form and report anything unusual to the charge nurse. **NOTE:** For the elderly, the average rectal temperature is 97.8 but may be as low as 96°F.			

Taking Axillary Temperature Using a Glass Oral Thermometer		**Yes**	**No**	**Comments**
1.	Wash your hands.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Provide privacy. Pull curtain around bed.			
6.	Take thermometer from its container. Rinse thermometer with cool water if it has been soaked in disinfectant solution, then dry it.			
7.	Check thermometer for breaks or chips.			
8.	Shake down thermometer to 94°F or below; firmly grasp at the stem end and snap your wrist several times.			
9.	Put cover on thermometer if used in your facility.			
10.	Instruct/assist patient to assume sitting or supine position. Lower side rail.			
11.	Help the patient remove an arm from the sleeve of the gown without exposing the patient.			
12.	Using a towel, dry axilla (armpit) of excessive perspiration.			
13.	Place bulb (mercury) end of thermometer in the center of patient's armpit.			
14.	Bring the arm across the chest and hold arm to snugly hold the thermometer in place for 10 to 12 minutes.			
15.	Lift arm and remove thermometer. Remove cover. If cover was not used, use tissue to wipe thermometer clean from the stem toward the bulb. **NOTE:** Do not pull thermometer out before lifting arm.			
16.	Read and record temperature reading. Note that it is an axillary temperature. Example: 95.8°A.			
17.	Shake down the thermometer and return to its container.			
18.	Remove, clean, and store equipment. Put towel with dirty linen.			
19.	Wash your hands.			
20.	Place patient's arm back in sleeve of gown.			
21.	Make the patient comfortable; place call signal within reach. Raise side rails if appropriate.			
22.	Record temperature on appropriate form and note that it is an axillary temperature, example 99.2°A. Report anything unusual to the charge nurse. **NOTE:** For the elderly, the average axillary temperature is 95.5, but may be as low as 94°F.			
Taking Axillary Temperature Using a Battery-Operated Electronic Oral Thermometer				
1.	Wash your hands.			
2.	Assemble equipment.			

Taking Axillary Temperature Using a Battery-Operated Electronic Oral Thermometer Cont.		**Yes**	**No**	**Comments**
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Check to be sure that the probe connector is plugged in tightly and that probe is blue.			
6.	Provide privacy. Pull curtain around bed.			
7.	Lower side rail. Remove the patient's arm from the sleeve of his gown. Dry the underarm with a towel.			
8.	Remove probe from its stored position. Insert probe into probe cover.			
9.	Put the covered probe in the center of the patient's armpit (axilla).			
10.	Put the patient's arm across his chest. Hold the probe in place.			
11.	Hold probe until the buzzer sounds or there is a flashing or steady light, then observe patient's temperature on the screen. Lift patient's arm and remove the probe from the patient's armpit.			
12.	Record temperature on paper or notepad. Note that it is axillary. Example. 95.8°A. **NOTE:** Record temperature before returning probe to its stored position. When you return probe, the reading automatically disappears.			
13.	Discard used probe cover by ejecting it into trash can. Do not touch probe tip.			
14.	Return the probe to the holder. **NOTE:** Store the thermometer in its charging stand when not in use. Battery gets recharged in this stand.			
15.	Put patient's arm back into sleeve of gown.			
16.	Remove, clean, and store equipment. Put towel with dirty linen.			
17.	Wash your hands.			
18.	Make the patient comfortable. Place call light within reach. Raise side rails if appropriate.			
19.	Record temperature on appropriate form and note that it is an axillary temperature. Report anything unusual to the charge nurse. **NOTE:** For the elderly, the average axillary temperature is 95.5, but may be as low as 94°F.			

Student's Signature/Date

Instructor's Signature/Date

Pulse and Respiration

Unit Objective

After completing this unit, you should be able to count a patient's radial pulse and count a patient's respirations.

Specific Objectives

After completing this unit, you should be able to:

A. Match terms in this unit with their correct definitions.

B. Count a radial pulse according to steps of procedure.

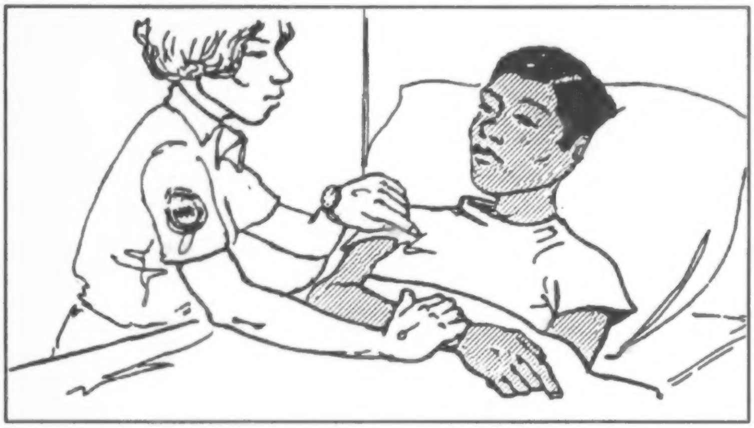
C. Count respirations according to steps of procedure.

Introduction

Each time the heart beats, it pumps blood into the arteries (blood vessels). This causes the arteries to swell. This swelling is called the "pulse." Between heartbeats, arteries return to normal. One of the easiest places to feel the pulse is at the wrist. This is called the radial pulse.

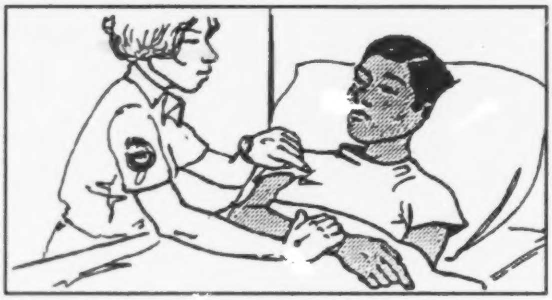
When pulse is checked, one also checks respiration. Respiration is the process of breathing air in and out.

In this unit, you will learn how to count a radial pulse and respirations.



A. Terms

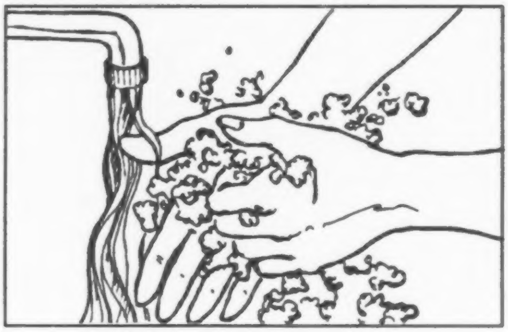
Radial pulse - pulse beat felt at the wrist



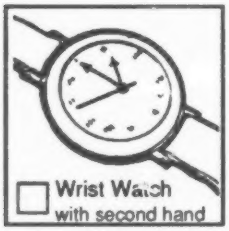
Respiration - process of breathing air in and out

B. Steps of Procedure for Counting a Radial Pulse

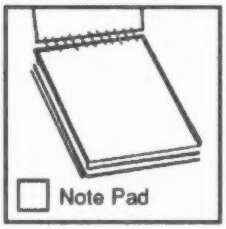
1. Wash your hands.



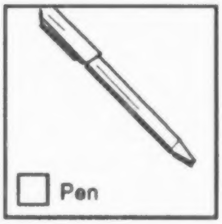
2. Assemble equipment.



☐ Wrist Watch with second hand



☐ Note Pad



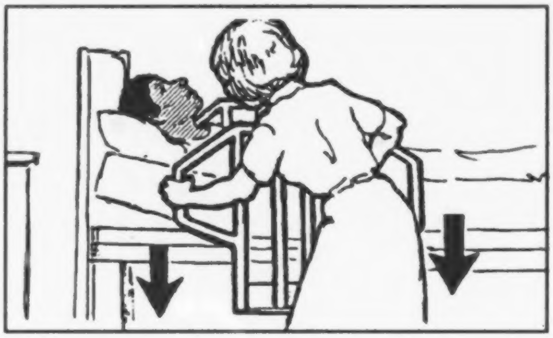
☐ Pen

3. Identify and greet patient. Identify self.

4. Explain that you are going to check the patient's vital signs.

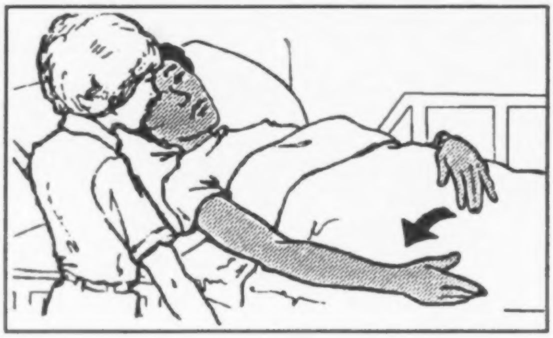
5. Provide privacy. Pull curtain around bed.

6. Lower side rail.

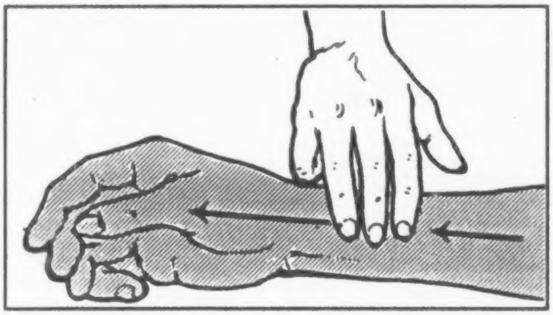


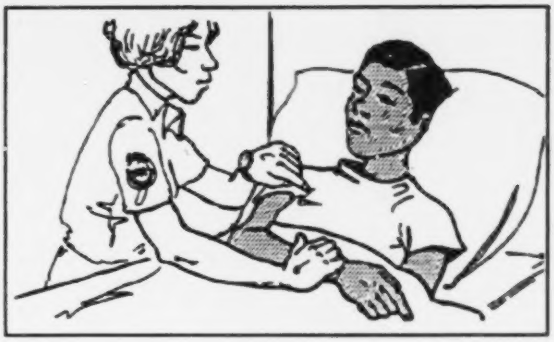
7. Resident should be in sitting or supine (back-lying) position.

8. Ask patient to put arm out straight.



9. Place the tips of your middle three fingers on inside of patient's wrist in line with patient's thumb. Fold patient's arm across chest.

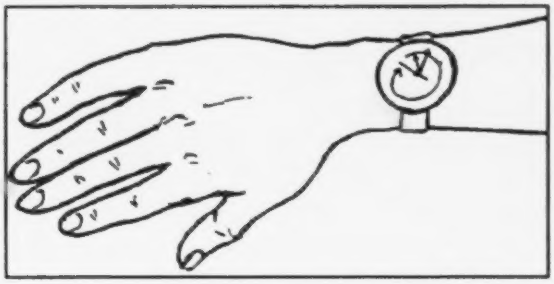




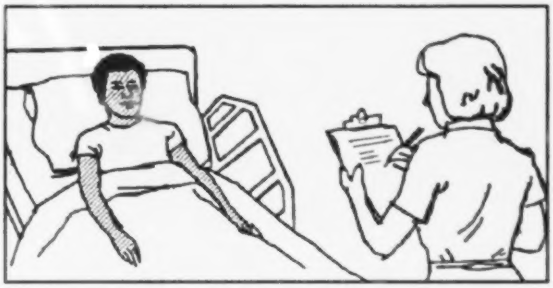
10. Press lightly until you feel the beat. If you press too hard, you will not be able to feel it.

NOTE: Never use your thumb. Your thumb has a pulse beat so you would be counting your pulse instead of the patient's.

11. Observe if pulse is strong or weak, regular or irregular.



12. Look at the second hand on the watch. Count the pulse beats you feel for one minute. Recount if you are unsure of pulse count.



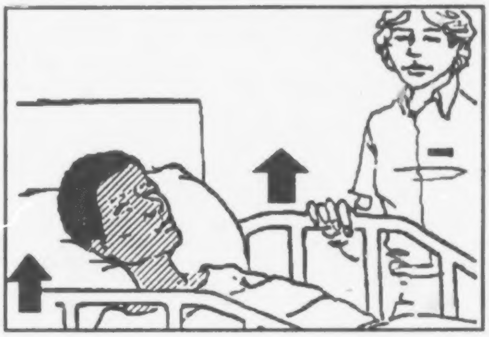
13. Record the pulse count on a piece of paper. Note any abnormal characteristics of the pulse.

NOTE: Normal pulse rates for adults is 60-100 beats per minute.

NOTE: If respirations are to be measured, count respirations now.

14. Make the patient comfortable. Place call light within reach.

15. Pull up side rails if appropriate.

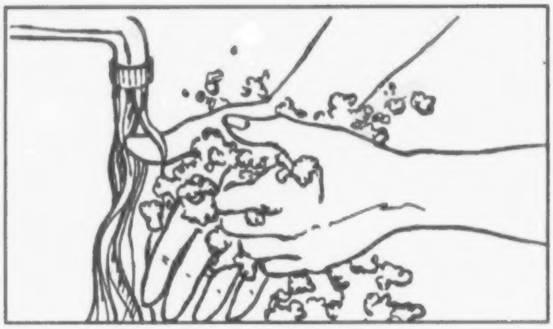


16. Wash your hands.

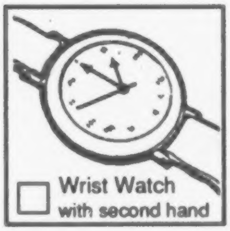
17. Record the pulse on the appropriate form and report to your supervisor if there was anything unusual, including an unusual pulse.

C. Steps of Procedure for Counting Respirations

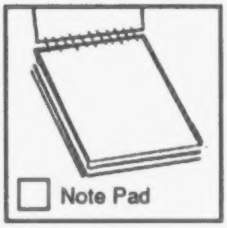
1. Wash your hands.



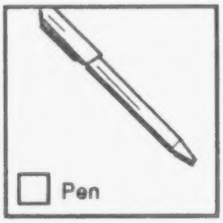
2. Assemble equipment.



☐ Wrist Watch with second hand



☐ Note Pad



☐ Pen

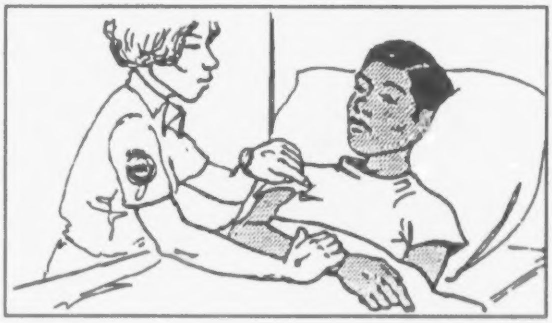
3. Identify and greet patient. Identify self.

4. Explain that you are going to check the patient's vital signs.

5. Provide privacy. Pull curtain around bed.

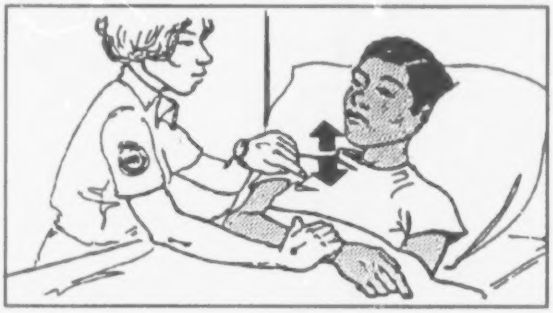
6. Lower side rail. Patient should be in sitting/supine position.

7. Hold patient's wrist as if you were taking a radial pulse when following pulse procedure.

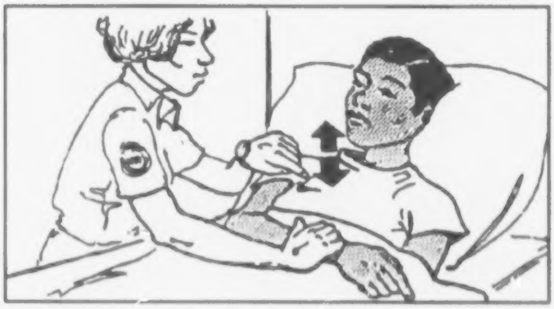


NOTE: Count patient's respirations, without patient knowing it, right after counting the pulse. It may cause the patient to breathe faster or slower if he is aware you are counting his respirations.

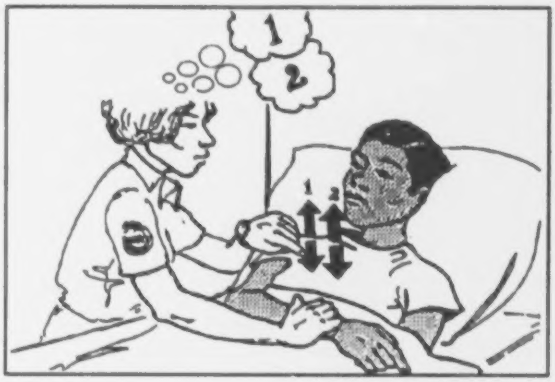
8. Observe the chest rise and fall. One rise and one fall of the chest counts as one respiration.



9. If you can't see the chest rise and fall then you can feel the breathing as you hold patient's wrist.

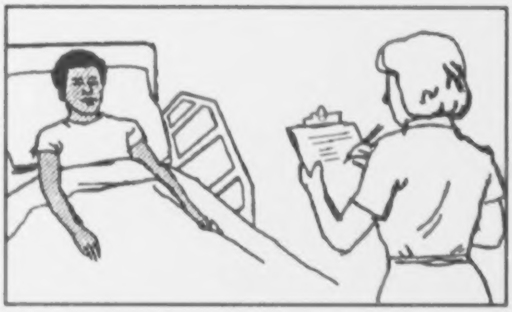


10. Look at second hand on your watch. Count "one" when you see patient's chest rising. The next time the chest rises, count "two." Count like this for one minute. Recount if you are unsure.



11. As you count, observe whether respirations seem noisy, labored or irregular.

12. Record number of respirations on a piece of paper.



NOTE: Normal respiration rates for adults is 14-20 per minute.

13. Wash your hands.

14. Make patient comfortable. Place call light within reach.

15. Pull up side rails if appropriate.

16. Record respirations on the appropriate form and report to your supervisor anything unusual, including anything unusual about the patient's respirations.

Pulse and Respiration
Written Evaluation

Circle the letter that corresponds to the best answer.

1. A radial pulse is a pulse beat felt:

    a. At the wrist.
    b. On the stomach.
    c. At the ankle.
    d. Over the heart.

2. One rise and fall of a patient's chest is:

    a. One respiration.
    b. Two respirations.
    c. Radial pulse.
    d. One inhalation.

3. The pulse should be counted for:

    a. Three minutes.
    b. One minute.
    c. Two minutes.
    d. Five minutes.

4. Respirations should be counted for:

    a. Two minutes.
    b. Three minutes
    c. One minute.
    d. Five minutes.

5. Respiration is:

    a. The ability to fight off a disease or infection.
    b. The flow of blood through the heart and blood vessels.
    c. The process of breathing air in and out.
    d. Inhaling food or foreign objects.

Pulse and Respiration
Evaluation

______________________has successfully performed the following steps of procedure.
(Student)

Counting a Radial Pulse		Yes	No	Comments
1.	Wash your hands.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Explain that you are going to check the patient's vital signs.			
5.	Provide privacy. Pull curtain around bed.			
6.	Lower side rail.			
7.	Resident should be in sitting/supine (back-lying) position.			
8.	Ask patient to put arm out straight.			
9.	Put tips of your middle three fingers on inside of patient's wrist in a line with patient's thumb. Fold patient's arm across chest.			
10.	Press lightly until you feel the beat. If you press too hard, you will not be able to feel it. **NOTE:** Never use your thumb. Your thumb has a pulse beat so you would be counting your pulse instead of the patient's.			
11.	Observe if pulse is strong or weak, regular or irregular.			
12.	Look at the second hand on the watch. Count the pulse beats you feel for one minute. Recount if you are unsure of pulse count.			
13.	Record the pulse count on a piece of paper. Note any abnormal characteristics of the pulse. **NOTE:** Normal pulse rates for adults is 60-100 beats minute. **NOTE:** If respirations are to be measured, count respirations now.			
14.	Make the patient comfortable. Place call light within reach.			
15.	Pull up side rails if appropriate.			
16.	Wash your hands.			
17.	Record the pulse on the appropriate form and report to your supervisor if there was anything unusual, including an unusual pulse.			

Counting Respirations		Yes	No	Comments
1.	Wash your hands.			
2.	Assemble equipment.			
3.	Identify and greet patient. Identify self.			
4.	Explain that you are going to check the patient's vital signs.			
5.	Provide privacy. Pull curtain around bed.			
6.	Lower side rail. Patient should be in sitting/supine position.			
7.	Hold patient's wrist as if you were taking a radial pulse when following pulse procedure. **NOTE**: Count patient's respirations, without patient knowing it, right after counting the pulse. It may cause the patient to breathe faster or slower, if he is aware you are counting his respirations.			
8.	Observe the chest rise and fall. One rise and one fall of the chest counts as one respiration.			
9.	If you can't see the chest rise and fall then you can feel the breathing as you hold patient's wrist.			
10.	Look at second hand on your watch. Count "one" when you see patient's chest rising. The next time the chest rises, count "two." Count like this for one full minute. Recount if you are unsure.			
11.	As you count, observe whether respirations seem noisy, labored or irregular.			
12.	Record number of respirations on a piece of paper. **NOTE:** Normal respiration rates for adults is 14-20 per minute.			
13.	Wash your hands.			
14.	Make patient comfortable. Place call light within reach.			
15.	Pull up side rails if appropriate.			
16.	Record respirations on the appropriate form and report to your supervisor anything unusual, including anything unusual about the patient's respirations.			

Student's Signature/Date

Instructor's Signature/Date

Blood Pressure

Unit Objective

After completing this unit, you should be able to measure blood pressure using a mercury and aneroid blood pressure apparatus.

Specific Objectives

After completing this unit, you should be able to:

A. Match terms in this unit with their correct definitions.

B. Measure a patient's blood pressure using aneroid and a mercury blood pressure apparatuses according to steps of procedure.

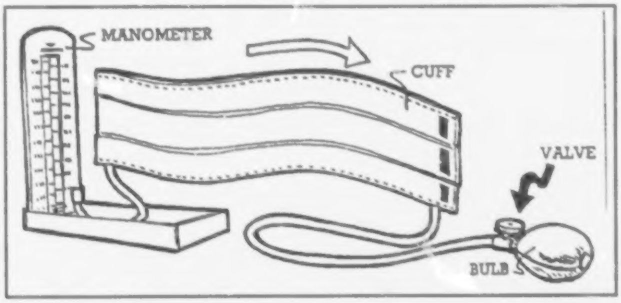
Introduction

Blood is pumped by the heart into the arteries. Blood pressure is the force of blood pushing against the wall of the arteries. It is this force or pressure that health care providers measure when "taking a blood pressure." Blood pressure is measured with a sphygmomanometer or blood pressure apparatus (cuff) and a stethoscope.

There are two types of blood pressure apparatuses (cuffs). One is the mercury type and the other is the aneroid type. When you measure blood pressure, you listen with the stethoscope and watch either a level of mercury or a pointer on a dial.

Blood pressure is a vital sign because it is essential in determining the condition of the patient. It is recorded as one number over another number. The top number is systolic pressure. The bottom number is the diastolic pressure. Example: 120/80.

In this unit, you will learn how to measure (take) a blood pressure using aneroid and mercury blood pressure apparatuses.

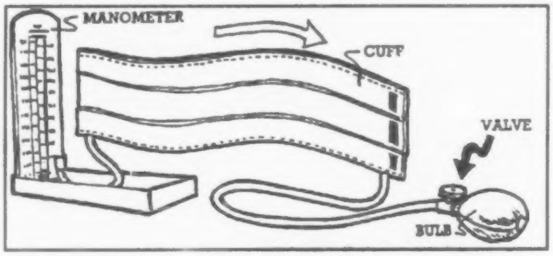


A. Terms

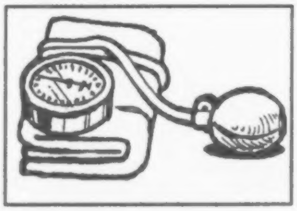
Blood pressure - force of blood pushing against the walls of arteries

Blood pressure cuff - device which wraps around a patient's arm to measure blood pressure; it is connected to a manometer

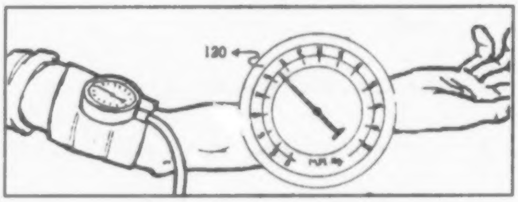
Mercury manometer - an upright gauge that uses mercury to measure blood pressure; read blood pressure by looking at level of mercury



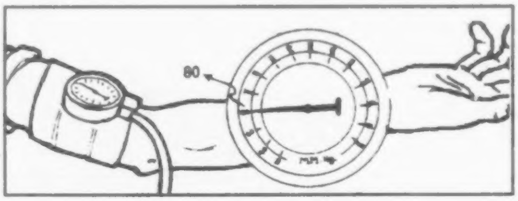
Aneroid manometer - a round gauge that uses a spring to measure blood pressure; read blood pressure by looking at where the spring is pointed when you hear the beat



Systolic pressure - top number in the blood pressure reading when the heart contracts; the number where you first hear the beat



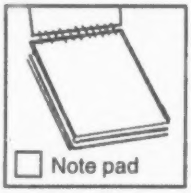
Diastolic pressure - bottom number in the blood pressure reading when the heart is at rest; the number where you last hear the beat

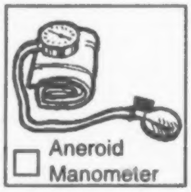


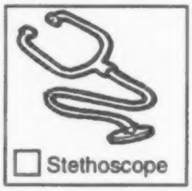
SYSTOLIC
120/
DIASTOLIC
80

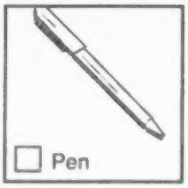
B. Steps of Procedure for Taking Blood Pressure

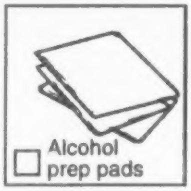
1. Assemble equipment.

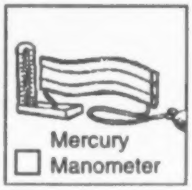



☐ Aneroid Manometer

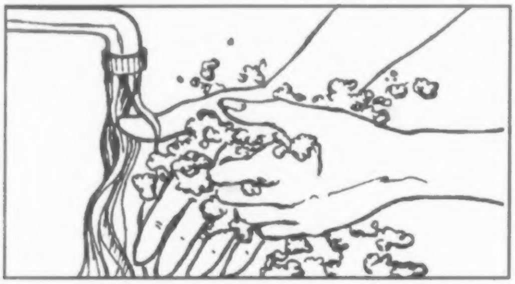

☐ Stethoscope



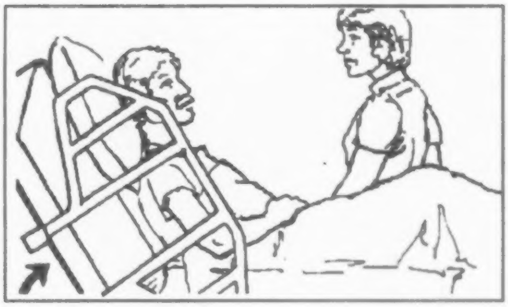

☐ Alcohol prep pads


☐ Mercury Manometer

2. Wash your hands.

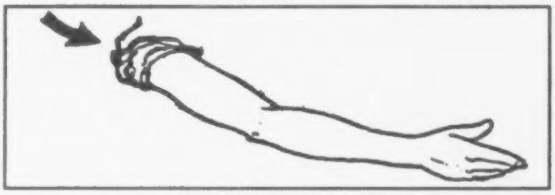


3. Identify and greet patient. Identify self.
4. Explain what you are going to do.
5. Provide privacy. Pull curtain around bed.
6. Position patient seated or reclining.



7. Lower side rail if patient is in bed.

8. Roll patient's sleeve well above the elbow. If sleeve is too tight to take blood pressure reading, take arm out of clothing.

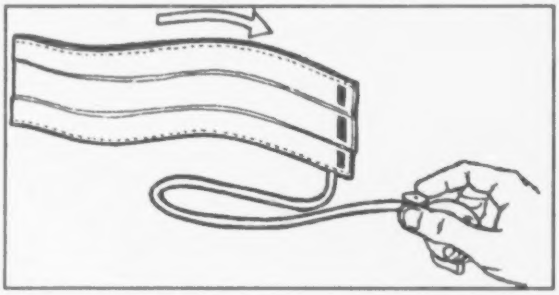


NOTE: Do not apply cuff over clothing.

9. Patient's entire lower arm should be on a flat surface with palm upward.

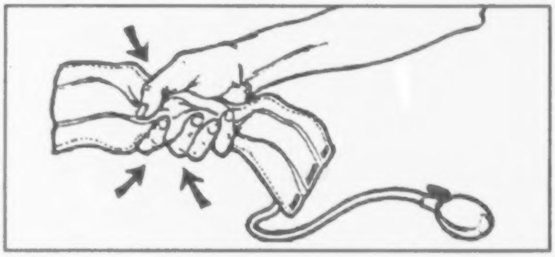
CAUTION: Blood pressure should never be taken on a paralyzed arm, an arm with an IV infusion or a cast, or on the same side as was a breast surgery.

10. Unroll blood pressure cuff.



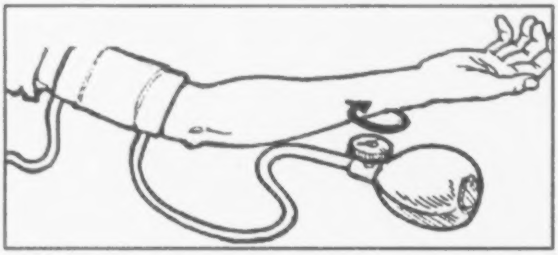
11. Loosen valve on the bulb.

12. Squeeze cuff to be sure all of the air is out of it.

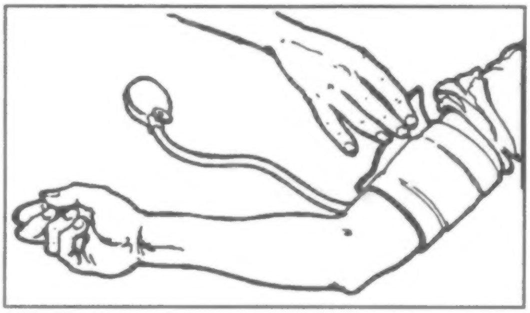


13. Turn the valve on the bulb clockwise to close it.

NOTE: Do not turn it too tightly or you will have trouble opening it.



14. Wrap cuff snugly around the patient's upper arm, at least one inch above the elbow.

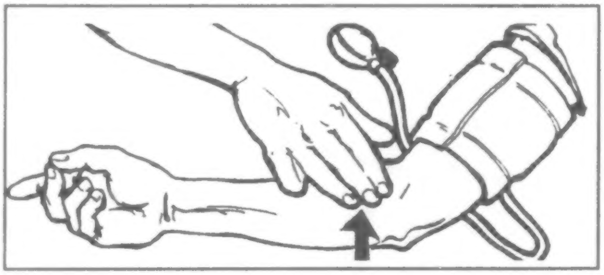


NOTE: Do not wrap cuff so tightly that patient is uncomfortable.

15. Be sure dial or mercury column is positioned so that you can read it easily.

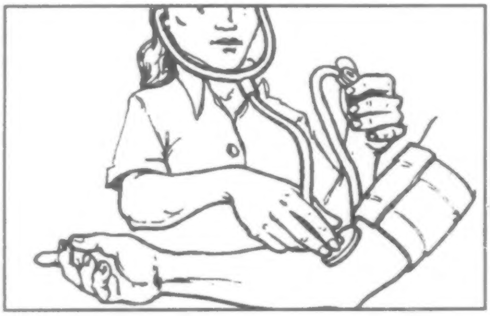
16. Clean earpieces and diaphragm of stethoscope with an alcohol pad.

17. With your three middle fingers, press lightly over the inner aspect of the arm at the bend of the elbow. You should feel a pulse. This is the brachial pulse.



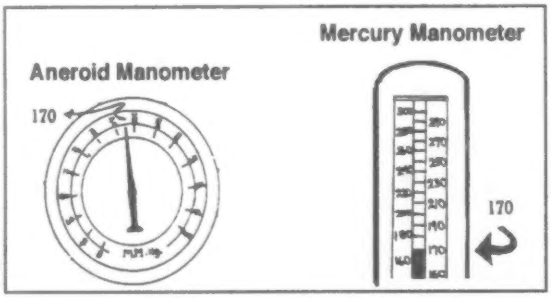
18. Put earpieces of stethoscope in your ears.

19. Place diaphragm of stethoscope over area where you feel the pulse. Hold stethoscope in place with your fingers.

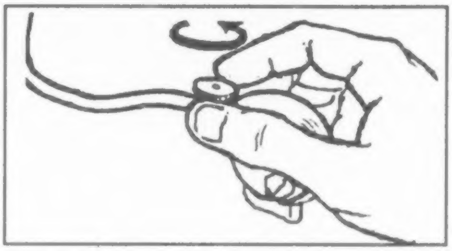


NOTE: Do not hold in place with your thumb.

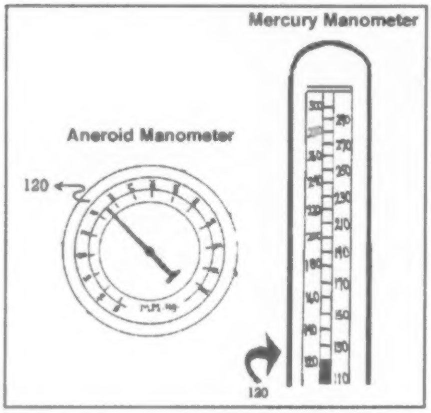
20. With your other hand, squeeze rubber bulb until pointer or mercury level is at 170-200 mm Hg.



21. Slightly loosen the valve, turning it counterclockwise, letting air out slowly until you hear the sound of pulse.

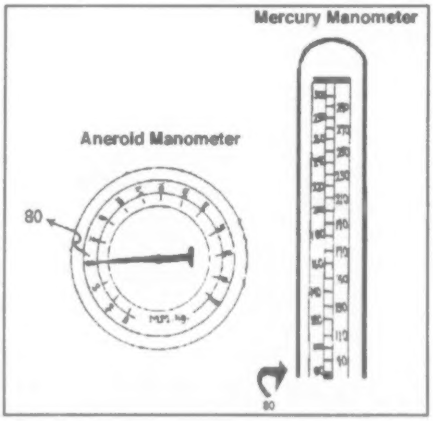


22. Note the number that the mercury or pointer passes when you hear the first sound. This number is the systolic pressure (top number).



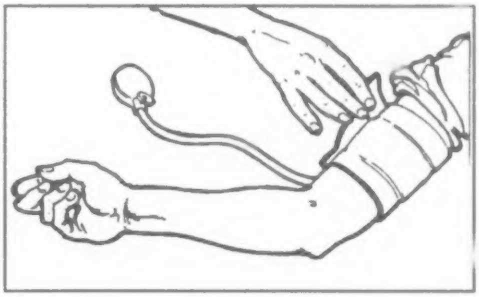
NOTE: If you immediately hear sounds upon opening the valve, stop the procedure. Let all the air out and remove the cuff. Wait 15 seconds, exercise arm and repeat procedures. Inflate cuff to 200-220 mm Hg. If sound is heard at 220 mm Hg, report to your supervisor immediately.

23. Continue releasing air from cuff slowly. When sounds change to a softer and muffled thump or when they disappear, note this number. This is the diastolic pressure (bottom number).



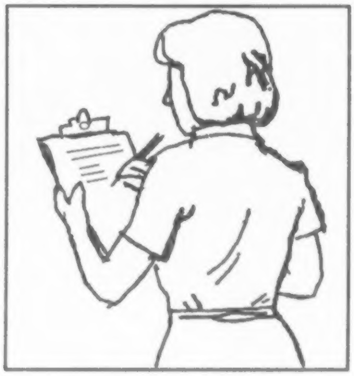
NOTE: If the sound remains a muffled thump down to zero, record the diastolic pressure at the point when you hear the change from a clear distinct sound to a muffled one and when the sound ends. Example: 120/80/0.

24. Let all the air out of the blood pressure cuff and remove it.

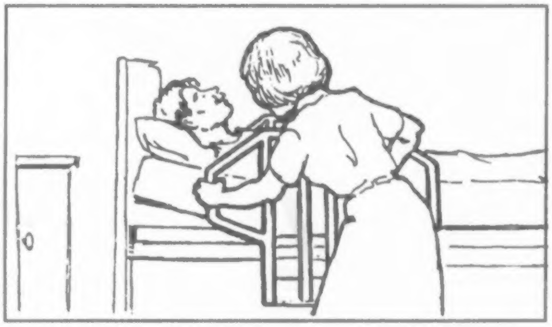


25. Remove the stethoscope from your ears.

26. Record blood pressure reading on paper.

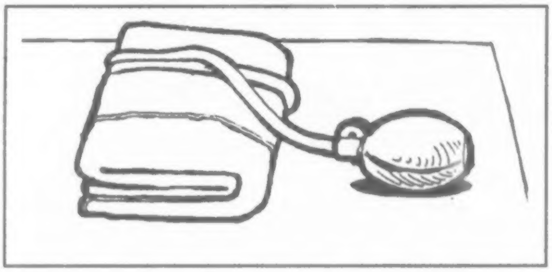


27. Make patient comfortable. Place call light within reach. Pull up side rails if appropriate.



28. Clean earpieces and diaphragm of stethoscope with alcohol pad.

29. Roll up blood pressure cuff and put it and manometer away.



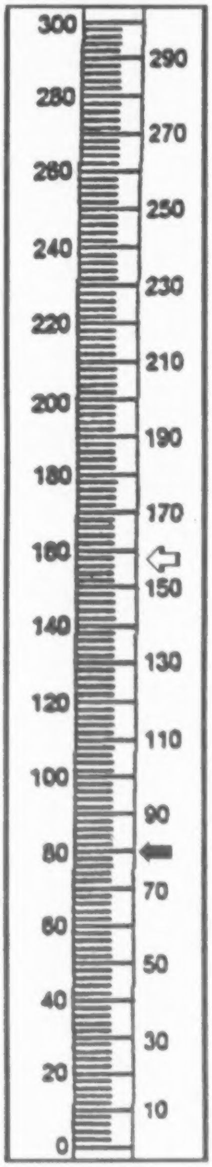
30. Wash your hands.

31. Record blood pressure on appropriate form used by facility.

32. Report to your supervisor if systolic pressure is over 150 mm Hg or lower than 100 mm Hg and if the diastolic pressure is over 90 mm Hg or lower than 60 mm Hg. Also report anything unusual to your supervisor.

Blood Pressure
Skill Sheet 1

Directions: Write each of the following blood pressure readings in the blank space by the gauge. The open arrow shows when you heard the first sound, systolic reading. The solid black arrow shows when you take the second reading, the diastolic reading. For number 6, tell which readings you would report to your supervisor.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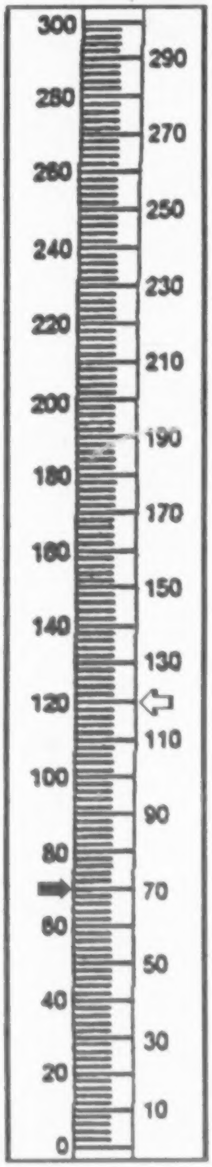
1. __________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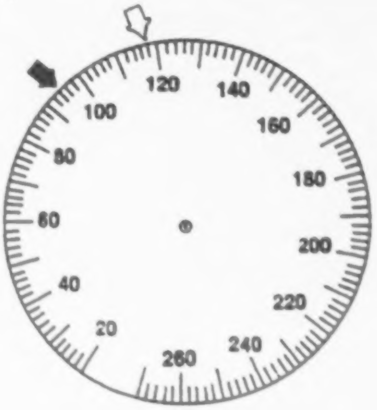
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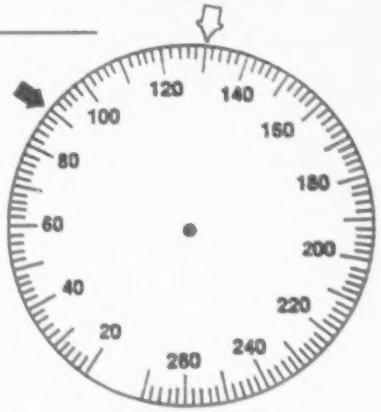
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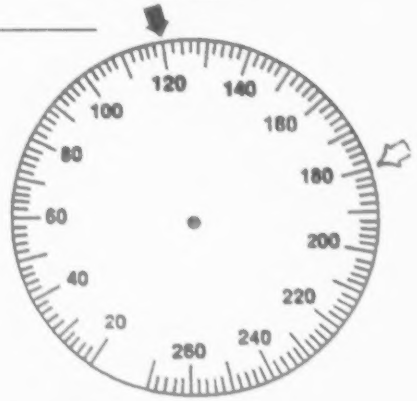
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160
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200
220
240
260

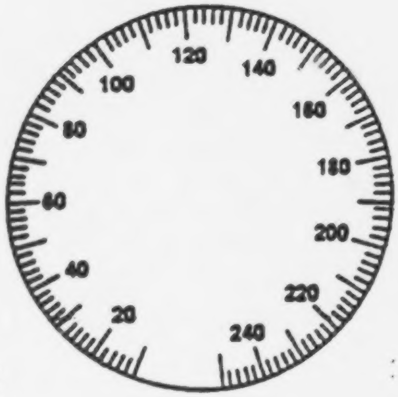
5. __________

6. __________

Blood Pressure

Skill Sheet 2

Directions: Beside each sphygmomanometer gauge is a BP reading: the systolic and diastolic numbers. Mark the gauge by extending a line out from the correct systolic reading and a line from the correct diastolic reading. Note: Each line on the gauge represents 2/10 mm. Hg.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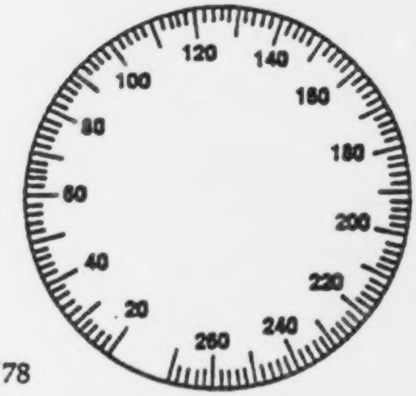
158/102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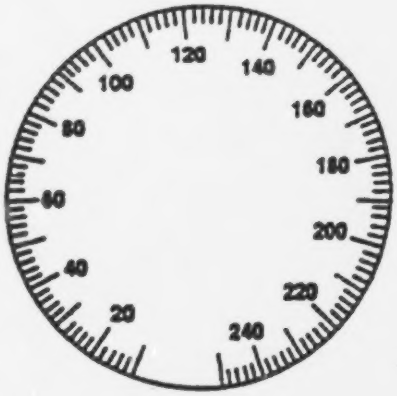
92/78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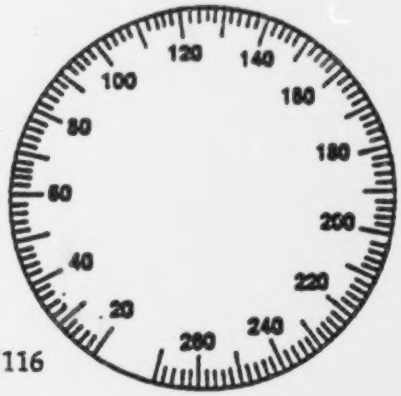
92/48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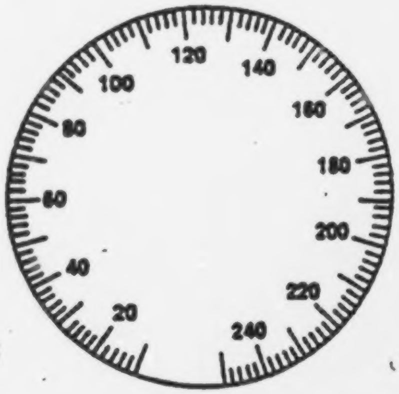
182/116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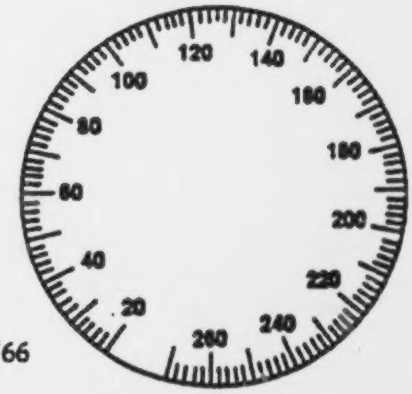
220/108


120
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160
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180
60
200
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220
20
260
240

82/66

Blood Pressure

Written Evaluation

Circle the letter that corresponds to the best answer.

1. If a patient's blood pressure is 140/80 mm Hg, the patient's diastolic pressure is:

   a. 140 mm Hg.
   b. 80 mm Hg.
   c. 140/80 mm Hg.
   d. Cannot be determined

2. If a patient's blood pressure is 150/100 mm Hg, the patient's systolic pressure is:

   a. 100 mm Hg.
   b. 150 mm Hg.
   c. 150/100 mm Hg.
   d. Cannot be determined

3. Two pieces of equipment needed to measure a blood pressure are:

   a. Blood pressure cuff and stethoscope.
   b. Chair and bed.
   c. Table and chair.
   d. Telescope and gauge.

Match terms in Column A with definitions in Column B.

Column A

_____ 4. Diastolic pressure

_____ 5. Blood pressure cuff

_____ 6. Systolic pressure

_____ 7. Blood pressure

Column B

a. Top number in the blood pressure reading when the heart contracts
b. Force of blood pushing against the walls of arteries
c. Device held in one hand to give support to a patient while ambulating
d. Bottom number in the blood pressure reading
e. Device which wraps around a patient's arm to measure blood pressure

Blood Pressure

Written Evaluation

Circle the letter that corresponds to the best answer.

1. If a patient's blood pressure is 140/80 mm Hg, the patient's diastolic pressure is:
   a. 140 mm Hg.
   b. 80 mm Hg.
   c. 140/80 mm Hg.
   d. Cannot be determined

2. If a patient's blood pressure is 150/100 mm Hg, the patient's systolic pressure is:
   a. 100 mm Hg.
   b. 150 mm Hg.
   c. 150/100 mm Hg.
   d. Cannot be determined

3. Two pieces of equipment needed to measure a blood pressure are:
   a. Blood pressure cuff and stethoscope.
   b. Chair and bed.
   c. Table and chair.
   d. Telescope and gauge.

Match terms in Column A with definitions in Column B.

Column A

_____ 4. Diastolic pressure

_____ 5. Blood pressure cuff

_____ 6. Systolic pressure

_____ 7. Blood pressure

Column B

a. Top number in the blood pressure reading when the heart contracts
b. Force of blood pushing against the walls of arteries
c. Device held in one hand to give support to a patient while ambulating
d. Bottom number in the blood pressure reading
e. Device which wraps around a patient's arm to measure blood pressure

Blood Pressure
Written Evaluation

Circle the letter that corresponds to the best answer.

1. If a patient's blood pressure is 140/80 mm Hg, the patient's diastolic pressure is:

   a. 140 mm Hg.
   b. 80 mm Hg.
   c. 140/80 mm Hg.
   d. Cannot be determined

2. If a patient's blood pressure is 150/100 mm Hg, the patient's systolic pressure is:

   a. 100 mm Hg.
   b. 150 mm Hg.
   c. 150/100 mm Hg.
   d. Cannot be determined

3. Two pieces of equipment needed to measure a blood pressure are:

   a. Blood pressure cuff and stethoscope.
   b. Chair and bed.
   c. Table and chair.
   d. Telescope and gauge.

Match terms in Column A with definitions in Column B.

Column A

_____ 4. Diastolic pressure

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_____ 6. Systolic pressure

_____ 7. Blood pressure

Column B

a. Top number in the blood pressure reading when the heart contracts
b. Force of blood pushing against the walls of arteries
c. Device held in one hand to give support to a patient while ambulating
d. Bottom number in the blood pressure reading
e. Device which wraps around a patient's arm to measure blood pressure

Blood Pressure
Evaluation

________________has successfully performed the following steps of procedure.
(Student)

Taking Blood Pressure		Yes	No	Comments
1.	Assemble equipment.			
2.	Wash your hands.			
3.	Identify and greet patient. Identify self.			
4.	Explain what you are going to do.			
5.	Provide privacy. Pull curtain around bed.			
6.	Position patient seated or reclining.			
7.	Lower side rail if patient is in bed.			
8.	Roll patient's sleeve well above the elbow. If sleeve is too tight to take blood pressure reading, take arm out of clothing. **NOTE:** Do not apply cuff over clothing.			
9.	Patient's entire lower arm should be on a flat surface with palm upward. **CAUTION:** Blood pressure should never be taken on a paralyzed arm, an arm with an IV infusion or a cast, or on the same side as was a breast surgery.			
10.	Unroll blood pressure cuff.			
11.	Loosen valve on the bulb.			
12.	Squeeze cuff to be sure all of the air is out of it.			
13.	Turn the valve on the bulb clockwise to close it. **NOTE:** Do not turn it too tightly or you will have trouble opening it.			
14.	Wrap cuff snugly around the patient's upper arm, at least one inch above the elbow. **NOTE:** Do not wrap cuff so tightly that patient is uncomfortable.			
15.	Be sure dial or mercury column is positioned so that you can read it easily.			
16.	Clean earpieces and diaphragm of stethoscope with an alcohol pad.			
17.	With your three middle fingers, press lightly over the inner aspect of the arm at the bend of the elbow. You should feel a pulse. This is the brachial pulse.			
18.	Put earpieces of stethoscope in your ears.			
19.	Place diaphragm of stethoscope over area where you feel the pulse. Hold stethoscope in place with your fingers. **NOTE:** Do not hold in place with your thumb.			

Taking Blood Pressure Cont.		Yes	No	Comments
20.	With your other hand, squeeze rubber bulb until pointer or mercury level is at 170-200 mm Hg.			
21.	Slightly loosen the valve, turning it counterclockwise, letting air out slowly until you hear the sound of pulse.			
22.	Note the number that the mercury or pointer passes when you hear the first sound. This number is the systolic pressure (top number). **NOTE:** If you immediately hear sounds upon opening the valve, stop the procedure. Let all the air out and remove the cuff. Wait 15 seconds, exercise arm and repeat procedures. Inflate cuff to 200-220 mm Hg. If sound is heard at 220 mm Hg, report to your supervisor immediately.			
23.	Continue releasing air from cuff slowly. When sounds change to a softer and muffled thump or when they disappear, note this number. This is the diastolic pressure (bottom number). **NOTE:** If the sound remains a muffled thump down to zero, record the diastolic pressure at the point when you hear the change from a clear distinct sound to a muffled one and when the sound ends. Example: 120/80/0.			
24.	Let all the air out of the blood pressure cuff and remove it.			
25.	Remove the stethoscope from your ears.			
26.	Record blood pressure reading on paper.			
27.	Make patient comfortable. Place call light within reach. Pull up side rails if appropriate.			
28.	Clean earpieces and diaphragm of stethoscope with alcohol pad.			
29.	Roll up blood pressure cuff and put it and manometer away.			
30.	Wash your hands.			
31.	Record blood pressure on appropriate form used by facility.			
32.	Report to your supervisor if systolic pressure is over 150 mm Hg or lower than 100 mm Hg and if the diastolic pressure is over 90 mm Hg or lower than 60 mm Hg. Also report anything unusual to your supervisor.			

Student's Signature/Date

Instructor's Signature/Date

90-5642-I

SKILLS FOR Health Care Assistants Vol. II

Supplemental Units for Health Care and Nurse Assistants Programs

Instructor Key

Produced by the
Instructional Materials Laboratory
University of Missouri-Columbia
and the
Department of Elementary and Secondary Education
Jefferson City, Missouri

Available from:
Instructional Materials Laboratory
University of Missouri-Columbia
2316 Industrial Drive
Columbia, MO 65202
800-669-2465 or 314-882-2883

"The activity which is the subject of this report was supported in whole or in part by funds from the Department of Elementary and Secondary Education, Division of Vocational and Adult Education. However, the opinions expressed herein do not necessarily reflect the position or policies of the Missouri Department of Elementary and Secondary Education or the Division of Vocational and Adult Education, and no official endorsement should be inferred."

SKILLS FOR

Health Care Assistants

Volume II

Supplemental Units for Health Care and Nurse Assistants Programs

Instructor Key

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Produced by the Instructional Materials Laboratory
University of Missouri-Columbia • 10 London Hall • Columbia, Missouri 65211
314-882-2883

July 1982
Revised August 1994

Catalog Number 90-5642-I

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Hair Care .... Unit 7
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Skills for Health Care Assistants

Preface

Skills for Health Care Assistants Volume II replaces the Health Services: Vocational Preparation Curriculum. The original manual was designed to provide supplementary materials for students with special needs who were enrolled in regular health services courses. The advisory committee for Volume I recommended that two curriculum guides, Supplementary Units for Nurse Assistant in a Long-Term Care Facility and Health Services: Vocational Preparation Curriculum be revised and combined under a new title, Skills for Health Care Assistants.Volume I was completed in 1993. Skills for Health Care Assistants curriculum was sponsored by the Missouri Department of Elementary and Secondary Education.

The units are self-paced and contain simplified line drawings, controlled text, vocabulary development, and math practice exercises. For ease of use by students with special needs, the color-coding has been changed to the following:

White: Objectives, introduction to the unit, content outline, and steps of procedure are white pages.

Pink: Skill sheets, written evaluations, and practical evaluations are pink pages. They are completed by the student and used by the instructor to evaluate student performance. Different forms of review, including matching, multiple-choice, and short answer exercises, are provided. Practical evaluations are included where appropriate. All pink sheets are to be returned to the instructor.

Instructor Key contains activities, answer keys for skill sheets, and answers for written evaluations for each unit.

Skills for Health Care Assistants

General Notes to the Instructor

1. Read through the information in each unit before presenting it to the student.

2. Make sure all equipment to be used in each unit is available.

3. Prepare any handouts, visuals, or supplemental material to aid student learning activities.

4. Distribute the unit to be used.

5. Discuss the introduction and objectives with the student. At this time, you can also discuss the terms in the unit.

6. Select a means to present the Steps of Procedure. (This will depend upon the capabilities of the student.)
   a. Have student study information independently.
   b. Go through the Steps of Procedure individually or as a group.
   c. Go through the material as a group, then have students work independently.

7. Instructor can demonstrate procedures to the student or class.

8. Allow student time to practice the procedure. Individual judgement by the instructor will determine proper amount of time.

9. Have student complete all Skill Sheets for the unit. Skill Sheets are not necessarily to be used as an exam by the instructor, but as a self-evaluation by the student and as points of discussion for the class. Handouts can also be used for more practice.

10. Complete any applicable activities listed in the Activities section of the instructor's guide.

11. When student is ready, use the written and/or practical evaluation to determine student's performance for that unit.

Additional Suggestions

- Try a team approach when possible:
  - Beginning students can work together after instructor's demonstrations.
  - One student experienced with the procedure can work with a beginner.
- For non-readers or ESL students, audio-visuals of the lessons can be prepared.
- Review equipment with students whenever necessary.
- Skill sheets can be used as a pencil and paper exercise or in any way the instructor feels it will help to clarify the material.
- Additional modifications can be made to take care of other disadvantaged/handicapped conditions unique to your situation.

Acknowledgments

Many individuals contributed to the development of Skills for Health Care Assistants Vol. II. The 1982 edition was called Health Services: Vocational Preparation Curriculum.

Writer (1982 edition):

Wanda M. Jones, Graduate Research Writer and Registered Nurse

Writer (1994 edition):

Sylvia Wright, RN, MSN, Health Occupations Instructor, St. Louis Special School District

Advisory Committee (1982 edition):

Miles Beachboard, Director of Vocational Special Needs Programs, Department of Elementary and Secondary Education, Jefferson City, Missouri

Yolanda Dolecki, RN, EdD, State Supervisor of Health Occupations Education, Jefferson City, Missouri

Beverly Jones, RN, Health Occupations Instructor, Lewis and Clark Technical School, St. Charles, Missouri

E. June Meyer, RN, MS, Coordinator of Adult Health Occupations, Kansas City Technical Education Center

Dick Omer, Supervisor of Vocational Special Needs Programs, Department of Elementary and Secondary Education, Jefferson City, Missouri

Sylvia Wright, RN, MSN, Health Occupations Instructor, St. Louis Special School District

Advisory Committee (1994 edition):

Steve Alexander, Supervisor of Vocational Special Needs and Guidance Services, Department of Elementary and Secondary Education

Lois Bonnot, Health Care Education Specialist, Missouri Division of Aging

Arden Boyer-Stephens, Vocational Resource Educator, Columbia Area Career Center

Sheri Clayton, Quality Assurance, St. Charles Health Care Center

Nancy Fedorchak, Health Occupations Instructor, Columbia Area Career Center

Delbert Lund, Supervisor of Vocational Planning & Evaluation, Department of Elementary and Secondary Education

Marilyn Moore, Allied Health Instructor, Cass County AVTS

Jane Scott, Supervisor of Health Occupations Education, Department of Elementary and Secondary Education

Sherry Struckhoff, Health Occupations Instructor, Waynesville AVTS

Instructional Materials Laboratory:

Harley Schlichting, Director

Phyllis Miller, Assistant Director

Dan Stapleton, Assistant Director

Veronica Feilner, Editor

Angela Alcala-Bach, Editorial Assistant

Bob Forsee, Graphic Designer

Jan Trimble, Word Processor III

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Activities, Answers to Skill Sheets, and Answers to Written Evaluations

Unit 1: Orientation to Health Services

A. Activities

1. Have students practice writing the abbreviations and their meaning.
2. Divide the class into teams. Using flashcards, have students quiz each other.
3. Role play the following situations:
    a. An assistant enters the room of a patient.
    b. Another assistant asks you to assist him/her in lifting a heavy patient.
4. Have students examine a sample chart or sample form used for nurse assistant charting.
5. Have students practice locking wheels on beds and changing the position of the hospital bed. Remember to raise side rails.
6. Discuss rules for fire prevention.

B. Answers to Written Evaluation

1. d
2. e
3. b
4. c
5. a
6. g
7. f
8. yes
9 yes
10. no
11. d
12. d
13. c
14. a
15. c
16. b

Unit 2: Handwashing

A. Activities

1. Demonstrate handwashing and have each student return demonstration.
2. Have students practice handwashing by requiring students to wash their hands upon entering class each day.

B. Answers to Written Evaluation

1. d
2. a
3. check 3, 4, 5, 6

Unit 3: Measuring Intake and Output

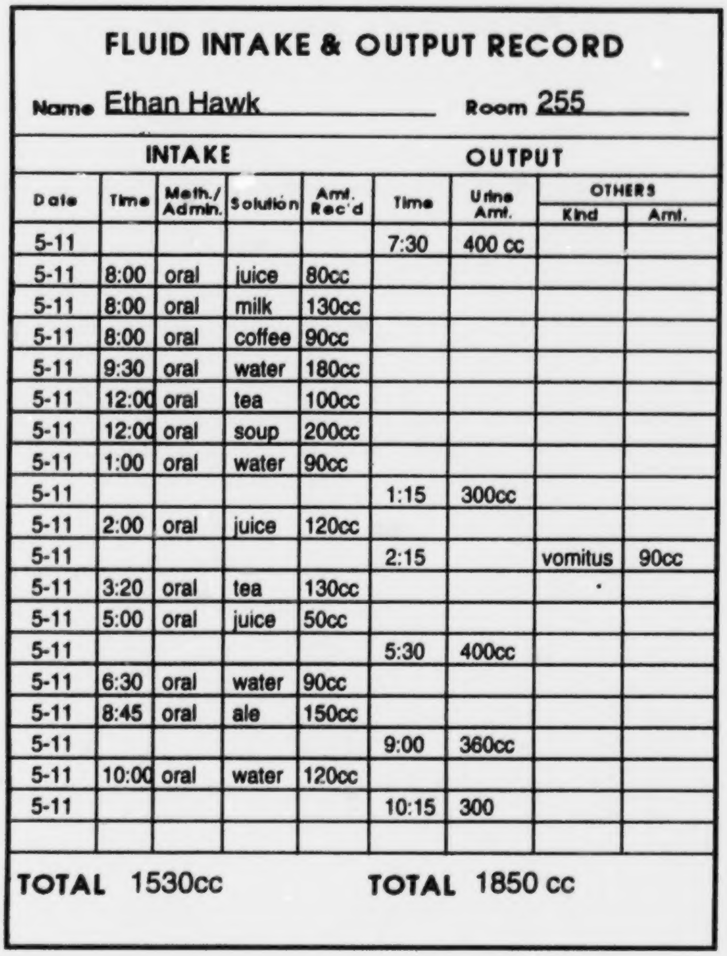
A. Activities

1. Have students complete skill sheets.
2. Fill graduates with different amounts of water and have students record the amount in each graduate.

B. Answers to Skill Sheets

1. Skill Sheet 1
    1. 40 cc
    2. 60 cc
    3. 20 oz, 600 cc
    4. 6 oz
    5. 10 oz, 300 cc
    6. 8 oz
    7. 1 1/2 oz
    8. 11 oz, 330 cc
    9. 5 oz
    10. 3 oz
    11. 12 oz
2. Skill Sheet 2
    1. 6 oz
    2. 60 cc
    3. a. 540
        b. 660
        Mrs. Cagney can have meal a.

4.



FLUID INTAKE & OUTPUT RECORD

Name Ethan Hawk **Room** 255

INTAKE					OUTPUT			
Date	Time	Meth./ Admin.	Solution	Amt. Rec'd	Time	Urine Amt.	OTHERS	
							Kind	Amt.
5-11					7:30	400 cc		
5-11	8:00	oral	juice	80cc				
5-11	8:00	oral	milk	130cc				
5-11	8:00	oral	coffee	90cc				
5-11	9:30	oral	water	180cc				
5-11	12:00	oral	tea	100cc				
5-11	12:00	oral	soup	200cc				
5-11	1:00	oral	water	90cc				
5-11					1:15	300cc		
5-11	2:00	oral	juice	120cc				
5-11					2:15		vomitus	90cc
5-11	3:20	oral	tea	130cc				
5-11	5:00	oral	juice	50cc				
5-11					5:30	400cc		
5-11	6:30	oral	water	90cc				
5-11	8:45	oral	ale	150cc				
5-11					9:00	360cc		
5-11	10:00	oral	water	120cc				
5-11					10:15	300		

TOTAL 1530cc **TOTAL** 1850 cc

C. Answers to Written Evaluation

1. b
2. a
3. c
4. d
5. d
6. d
7. b
8. a, b, e, f, g
9. vomitus
10. a. 180 cc
    b. 120 ml
    c. 240 ml
    d. 360 cc
    e. 1050 cc
    f. 600 cc
    g. 450 ml

Unit 4: Assist Patient in Using the Bedpan and Urinal

A. Activities

1. Using a mannequin, demonstrate assisting a patient to use the bedpan and urinal. Have students return demonstration.

B. Answers to Written Evaluation

1. b
2. c
3. a
4. e
5. d
6. c
7. b

Unit 5: Feeding the Patient

A. Activities

1. Demonstrate the following activities. Have students pair up to practice the procedures.
    - a. Serving trays
    - b. Preparing patients for meals
    - c. Assisting patients with a meal
    - d. Feeding a helpless patient
2. Prepare a meal in class to serve classmates.

B. Answers to Written Evaluation

1. b
2. a
3. b
4. a
5. b
6. c

Unit 6: Bathing

A. Activities

1. Demonstrate giving a bedbath to mannequin and have each student return demonstration.

2. Demonstrate assisting a patient with a complete bedbath and have each student return demonstration.

B. Answers to Written Evaluation

1. a
2. a
3. b

Unit 7: Hair Care

A. Activities

1. Demonstrate combing/brushing hair using a mannequin. Have students return demonstration.
2. Allow students to practice combing/brushing each other's hair.
3. Demonstrate shampooing a mannequin's hair in bed and have students return demonstration.

B. Answers to Written Evaluation

1. c
2. a
3. a
4. c
5. d

Unit 8: Mouth Care

A. Activities

1. Demonstrate setting up for and giving oral hygiene to a mannequin.

2. Demonstrate cleaning dentures. Have students return demonstration.

B. Answers to Written Evaluation

1. e
2. d
3. g
4. f
5. c
6. a
7. b
8. a

Unit 9: Shaving

A. Activities

1. Demonstrate shaving a patient using a mannequin. Have students return demonstration.

B. Answers to Written Evaluation

1. b
2. c
3. a
4. a
5. c
6. a
7. c

Unit 10: Giving a Backrub

A. Activities

1. Demonstrate giving a backrub to a mannequin.
2. Have students practice giving backrubs to mannequin.

B. Answers to Written Evaluation

1. a
2. c

Unit 11: Bedmaking

A. Activities

1. Demonstrate making an unoccupied bed.
2. Have students return demonstration and practice making unoccupied beds.
3. Using a mannequin, demonstrate making an occupied bed.
4. Have students pair up and practice making an occupied bed.

B. Answers to Written Evaluation

1. b
2. b
3. a

Unit 12: Body Mechanics

A. Activities

1. Discuss rules of good body mechanics.

2. Demonstrate the following procedures. Have students pair up to return demonstration and practice the procedures.

    a. Assist/raise patient's head and shoulders

    b. Assist/move patient to head of bed

    c. Move helpless patient to head of bed

    d. Move patient to one side of the bed

    e. Turn patient on side

    f. Turn patient to prone position

B. Answers to Written Evaluation

1. a
2. c
3. d

Unit 13: Transferring the Patient

A. Activities

1. Discuss safety measure that must be followed when transferring a patient.
2. Demonstrate the following procedures. Have students pair up to return demonstration and practice the procedures.
    a. Transfer a patient from bed to chair
    b. Transfer a patient from chair to bed
    c. Transfer a patient with a mechanical lift to and from a chair or wheelchair to and from a bed

B. Answers to Written Evaluation

1. b
2. a
3. d
4. c
5. b or strong side
6. hips or c

XX

Unit 14: Temperature

A. Activities

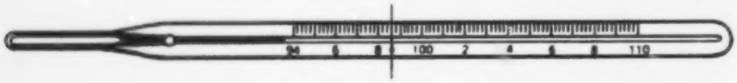
1. Have students complete skill sheets.
2. Have student practice reading Centigrade and Fahrenheit glass thermometers.
3. Have students practice shaking down glass thermometers below lowest number.
4. After viewing demonstration by instructor, have students practice measuring (taking) each other's oral temperatures using glass and electronic thermometers.
5. After viewing demonstration by instructor, have students practice inserting a glass or electronic rectal thermometer into rectum of a mannequin.
6. After viewing demonstration by instructor, have students measure (take) another student's axillary temperature using a glass and an electronic thermometer.

B. Answers to Skill Sheets

1. Skill Sheet 1

    1. 97
    2. 100.6
    3. 104.2

4.



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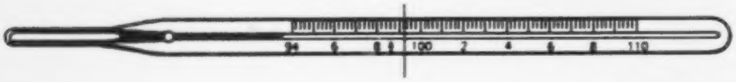

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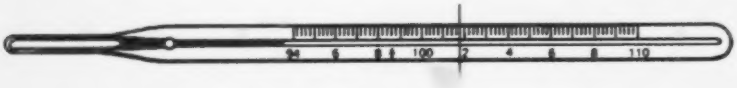

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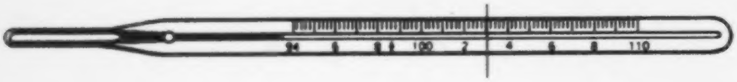
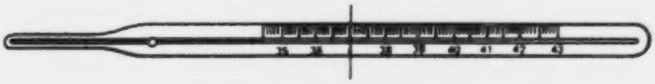


2. Skill Sheet 2

1. 37
2. 38.5
3. 39.5

4.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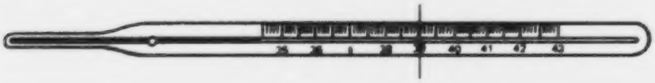
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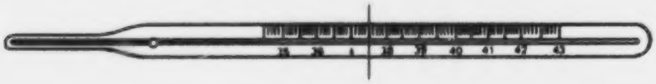
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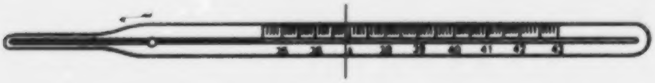
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C. Answers to Written Evaluation

1. a
2. b
3. a
4. b

Unit 15: Pulse and Respiration

A. Activities

1. Demonstrate measuring radial pulse. Have students practice measuring radial pulse on other students.
2. Demonstrate measuring respirations. Have students count respirations on other students.

B. Answers to Written Evaluation

1. a
2. a
3. b
4. c
5. c

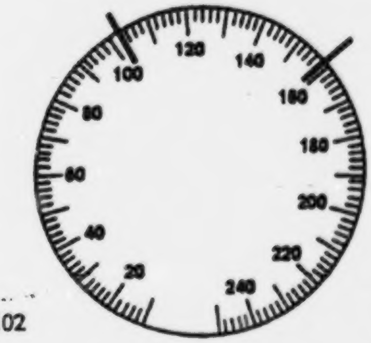
Unit 16: Blood Pressure

A. Activities

1. Have students complete skill sheets.
2. Demonstrate how the valve is used to release air slowly. Have students practice handling the air release valve until they can manage it smoothly.
3. Demonstrate measuring blood pressure. Have students practice measuring (taking) blood pressure readings on each other. Students should practice with both aneroid and mercury manometers.

B. Answers to Skill Sheets

1. Skill Sheet 1
   1. 158/80
   2. 120/70
   3. 118/94
   4. 130/90
   5. 140/120
   6. Report 1, 3 and 5.
2. Skill Sheet 2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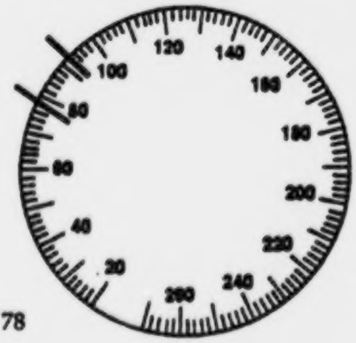
158/102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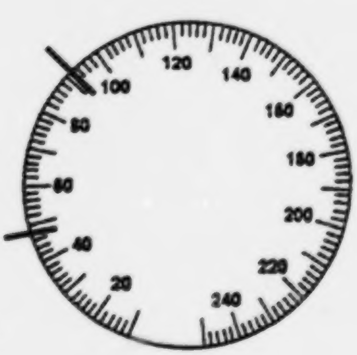
92/78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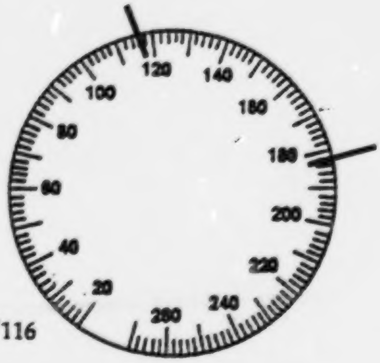
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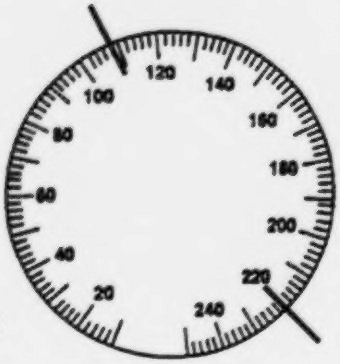
182/116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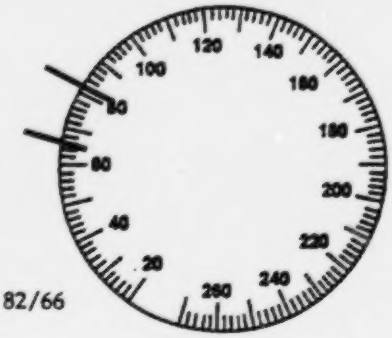
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260

82/66

C. Answers to Written Evaluation

1. b
2. b
3. a

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